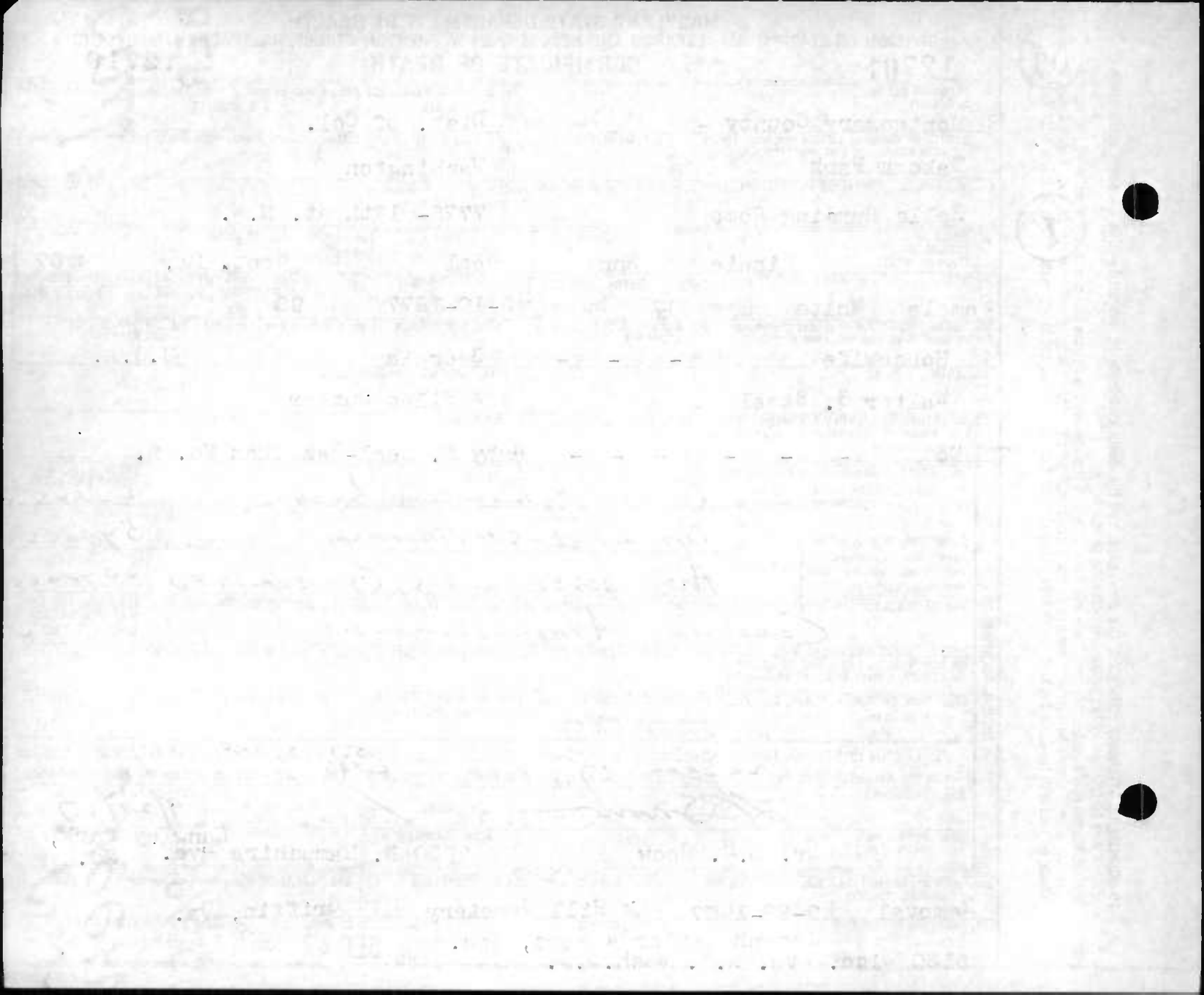


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12701					12710				
1. PLACE OF DEATH a. COUNTY Montgomery County -					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Col.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			d. STREET ADDRESS 7775- 17th St. N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ralls Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Minnie Ann Neal			4. DATE OF DEATH Sept. 21, 1967						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1877		9. AGE (In years last birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Georgia			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter S. Steel					14. MOTHER'S MAIDEN NAME Ellen Butler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. - - -		17. INFORMANT Ruby F. Neal-See Item No. 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL LOBAR 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MITRAL INSUFFICIENCY DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED								INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 YEARS 20 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ATHEROSCLEROSIS								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1950 to 21 SEPT. 1967 , that (I) (we) last saw the deceased alive on 20 SEPT 1967 , and that death occurred at 4:21 A.M. from the causes and on the date stated above.									
22a. SIGNATURE L.B. Snow					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/21/67		
22c. PHYSICIAN'S NAME (Type) Dr. L.B. Snow					22d. ADDRESS 7950 N. Hampshire Ave. Langley Park, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-22-1967		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			23d. LOCATION (City, town or county) (State) Griffin, Ga.		
24. FUNERAL DIRECTOR Joseph Gawler & Sons, Inc.					25a. REC'D BY REGISTRAR SEP 27 1967				
25b. REGISTRAR'S SIGNATURE John H. Juge									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12702

CERTIFICATE OF DEATH

12711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONT.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> PR. GEO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>23 day</u>		d. STREET ADDRESS <u>5004 36th AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LYNN M. NESBITT</u> First Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/24</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer- Supt. U. S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William L. Nesbitt</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Ruth Fuller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marcella L. Nesbitt same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Metastatic carcinoma of liver</u> DUE TO (c) <u>Adenocarcinoma of rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 15, 1967</u> to <u>Sept. 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept. 8, 1967</u> , and that death occurred at <u>10:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u> M.D.		22b. DATE SIGNED <u>Sept. 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>		22d. ADDRESS <u>345 University Blvd., W. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>9/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Co. Washington, D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

1. Name of deceased: *William E. Westcott*
2. Date of death: *August 1, 1911*
3. Place of death: *Home, 1015 1st St., N.E., Washington, D.C.*
4. Cause of death: *Heart failure*
5. Age at death: *68 years*
6. Sex: *Male*
7. Race: *White*
8. Occupation: *Engineer*
9. Marital status: *Married*
10. Name of spouse: *Elizabeth Westcott*
11. Name of informant: *Elizabeth Westcott*
12. Address of informant: *1015 1st St., N.E., Washington, D.C.*
13. Signature of informant: *[Signature]*
14. Date of statement: *August 1, 1911*

15. Name of physician: *Dr. J. H. Johnson*
16. Address of physician: *1015 1st St., N.E., Washington, D.C.*
17. Signature of physician: *[Signature]*
18. Date of statement: *August 1, 1911*

19. Name of undertaker: *John Doe*
20. Address of undertaker: *1015 1st St., N.E., Washington, D.C.*
21. Signature of undertaker: *[Signature]*
22. Date of statement: *August 1, 1911*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

12703

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12712

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville		d. STREET ADDRESS Gregg Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Penland Last Nichols		4. DATE OF DEATH Month Sept. Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-02
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR: Months 15 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Researcher		10b. KIND OF BUSINESS OR INDUSTRY Lawyers Title Co.	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Nichols		14. MOTHER'S MAIDEN NAME Marie Wildman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-26-7571	
17. INFORMANT Med. Records		Address MGH Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1450 TERMINAL PULMONARY CONGESTION DUE TO (b) METASTASIS, TRACHEO-LARYNGEAL DUE TO (c) SQUAMOUS CELL CARCINOMA, TONSIL		INTERVAL BETWEEN ONSET AND DEATH 18 Mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 9/12 , 19 67 , to 9/21 , 19 67 , that (2) (we) last saw the deceased alive on 9/30 , 19 67 , and that death occurred at 2:35am , from causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 9-21-67	
22c. PHYSICIAN'S NAME (Type) DONALD R. LEWIS, M.D.		22d. ADDRESS 700 CLOVERLY STREET, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-67	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles J...	
DATE SEP 25 1967			

Silver Spring, Mont. No.

Date of Death

9-23-07

Burial

Lavensville, Md.

Francis H. Barber

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12704

CERTIFICATE OF DEATH

12713

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 11403 Grayling Lane			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11403 Grayling Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN JOSEPH		First Middle Last MICRO JR.		4. DATE OF DEATH Month Day Year SEPT 8 1967			
5. SEX M		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8 December 1929		9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Price quotations		10b. KIND OF BUSINESS OR INDUSTRY Electric		11. BIRTHPLACE (County & State, or foreign country) Washington, DC			
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME John Joseph Nicro					
14. MOTHER'S MAIDEN NAME Mary T. Garzoni		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1951-1955					
16. SOCIAL SECURITY NO. 579-36-0424		17. INFORMANT Address Mary T. Nicro, 59 Adams St., NW, DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Sept 8 1967			
21. I certify that (I) (this hospital) attended the deceased from Sept 8 1967 to Sept 8 1967 that (I) (we) last saw the deceased alive on Sept 8 1967 and that death occurred at 12:05 M. from the causes and on the date stated above.							
22a. SIGNATURE Robert T. Thibadeau		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1,000 Old Georgetown Rd. Rockville, Maryland 20852		22b. DATE Sept 8-67			
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					
23b. DATE THEREOF 11 Sept. 1967		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, DC			
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME, INC. 7400 GEORGIA AVE. N.W.		25a. REC'D BY REGISTRAR SEP 11 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

This case closed with Medical Examiner

1. The first part of the paper is devoted to a review of the literature on the topic.

REV. 11-11-60

• 11 •

11-11-2011

W-2-H-10

E15013

10-110000-001

NOV 23 1974

CONFIDENTIAL - SECURITY INFORMATION

2591-2592

100 11 2

11 Sept. 1961. Rock Creek Cemetery

361 11 933

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12705

CERTIFICATE OF DEATH

12714

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 1401 Southern Ave. S.E.	
3. NAME OF DECEASED (Type or print) First EMIL Middle - Last NOTOVITZ		4. DATE OF DEATH Month Sept. Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Baking	
11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME un known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Earnest Nash		Address 4001 Loraum Lane Arl., Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Brain (Apoplexy) DUE TO (c) 6 mos		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to 9-18 , 19 67 , that (I) (we) last saw the deceased alive on 9-17 , 19 67 , and that death occurred at 7A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Sanford Randall		22b. DATE SIGNED 9-18-67	
22c. PHYSICIAN'S NAME (Type) Dr. Sanford Randall		22d. ADDRESS 3000 Veazey Terr., Wash., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-67	
23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cem.		23d. LOCATION (City or Town) (County) (State) Woodbridge N.J.	
24. FUNERAL DIRECTOR Goldberg Funeral Home		24a. REC'D BY REGISTRAR DATE SEP 19 1967	
24b. ADDRESS 4217 9th St., N.W.		24c. REGISTRAR'S SIGNATURE J. Charles Judge	

10-10-1941

EXHIBIT A - DEATH

10-10-1941

1

Name of Deceased		Date of Death	
John Doe		10-10-1941	
Place of Death		City of New York	
Cause of Death		Heart Disease	
Age at Death		45	
Sex		Male	
Race		White	
Religion		Catholic	
Marital Status		Married	
Occupation		Teacher	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Witness		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Registrar		[Signature]	
Signature of Clerk		[Signature]	
Signature of [Other]		[Signature]	

FOR STATE
HEALTH DEPT

12706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12715

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>11 hrs</u>				d. STREET ADDRESS <u>11801 Farmland Dr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>R</u> Middle <u>O'Halloran</u> Last				4. DATE OF DEATH <u>Sept 21</u> 19 <u>67</u> Month <u>Sept</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/2/13</u>	
9. AGE (In years last birthday) <u>54</u> YRS.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Continental Machine</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Allyn King Renwick</u>				14. MOTHER'S MAIDEN NAME <u>Grace White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>167-05-5723</u>		17. INFORMANT <u>Daniel O'Halloran-son-613 Murial St.</u> Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage, left cerebral</u>							
331X DUE TO							
(b) <u>Cerebral arteriosclerosis</u>							
DUE TO							
(c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22. DATE SIGNED <u>9/21/1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				Address (Street or P.O. box and county) <u>Rockville, Md.</u>			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE THEREOF <u>9/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City or town) (County) (State) <u>Pittsburg Pa.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> Address <u>Rockville, Md.</u>				25. REC'D BY REGISTRAR <u>SEP 25 1967</u> DATE			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12-12



12-12-12

12-12-12

12-12-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12707

CERTIFICATE OF DEATH

12716

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Virginia b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS 5713 Colfax Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nona Middle Elizabeth Last OLSON			4. DATE OF DEATH Month September Day 24 Year 1967		
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1920	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Birmingham, Alabama	
13. FATHER'S NAME Boyd Nakivell			14. MOTHER'S MAIDEN NAME Ann Bostrom		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 420 07 8916		17. INFORMANT Alexandria Address Virginia CDR Lester D. Olson, USN, 5713 Colfax Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the colon with widespread metastases 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from August 10 , 19 67 , to Sept. 24 , 19 67 that (X) (we) last saw the deceased alive on Sept. 24 , 19 67 , and that death occurred at 120P M, from causes and on the date stated above.					
22a. SIGNATURE R. W. Virgilio			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept. 25, 1967
22c. PHYSICIAN'S NAME (Type) R. W. VIRGILIO, M.D.			22d. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Murphy Funeral Home			ADDRESS 3524 Columbia Pike		25a. REC'D BY REGISTRAR SEP 28 1967
			25b. REGISTRAR'S SIGNATURE [Signature]		

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12717

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE FLORIDA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b SEBRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8214 Flower Avenue		d. STREET ADDRESS 115 BELLVUE AVE. 48-3	
3. NAME OF DECEASED (Type or print) ROBERT ELMER ORANGE		4. DATE OF DEATH 9-15-1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1933
9. AGE (In years, months, days) 34		IF UNDER 1 YEAR 84 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY CONSTR.	
11. BIRTHPLACE (State or foreign country) EAGLE ROCK, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PASCHAL H. ORANGE		14. MOTHER'S MAIDEN NAME MATTIE WILHELM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-05-7167A	
17. INFORMANT MRS. H.R. CROMER		Address (NIECE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. READ MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9-16-1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Sept 19-1967		23b. DATE THEREOF Sept 19-1967	
23c. NAME OF CEMETERY OR CREMATORY Leo Park Cemetery		23d. LOCATION (City or Town) (County) (State) Kipp Rd. P. Box 714	
24. FUNERAL DIRECTOR J. Arthur Walters		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

100



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12718

12709

FOR STATE HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b. approx. 2 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S.S. Silver Spring d. STREET ADDRESS 11200 Lockwood Drive e. IF RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Morris Ostrofsky		4. DATE OF DEATH Month 9 Day 24 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/18/1909 AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician Mgm.		10b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE	11. BIRTHPLACE (State or foreign country) Russia
13. FATHER'S NAME Asher OSTROFSKY		14. MOTHER'S MAIDEN NAME Dora Varlinski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 454-03-0154	17. INFORMANT Ruth Goodman , Address 11200 Lockwood Drive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Pittsburg, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL BURIAL	23b. DATE THEREOF 9/25/67	23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM	23d. LOCATION (City or Town) (County) (State) PITTSBURG, PENNSYLVANIA
24. FUNERAL DIRECTOR'S NAME (Type) LEVINSOHN & BROS., INC.		25a. REC'D BY REGISTRAR SEP 27 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

PROPERTY

Silver Spring

June 12, 1961

11200 Rockwood Drive

PROPERTY

PROPERTY

WIFE

MALE

June 12, 1961

Washington, D.C.

ROBERT

DATA VARIANTS

ASPECT OF PROBLEM

11200 Rockwood Drive

11200 Rockwood Drive
Washington, D.C.
June 12, 1961
PROPERTY
WIFE
MALE
DATA VARIANTS
ASPECT OF PROBLEM
11200 Rockwood Drive
Washington, D.C.
June 12, 1961
PROPERTY
WIFE
MALE
DATA VARIANTS
ASPECT OF PROBLEM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. DEPTON STREET, BALTIMORE, MARYLAND 21201											
12710				CERTIFICATE OF DEATH				12719			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY PR GEO.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)				c. LENGTH OF STAY IN 15 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital						d. STREET ADDRESS Parkway Apt. 2, 7604 District Heights				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evangeline Middle PARSONS Last PARSONS						4. DATE OF DEATH Month September Day 7 Year 19 67					
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1915		9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Massachusetts				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emanuel Anderson						14. MOTHER'S MAIDEN NAME Alexandria Hukka					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 540 16 3956		17. INFORMANT Apt. 2 District Heights Md. Harold L. Root 7604 District Heights Pkwy					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ENCEPHALOMALACIA OF THE BRAIN DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from August 31, 1967 , to Sept. 7, 1967 , that (X) (we) last saw the deceased alive on Sept. 7, 1967 , and that death occurred at 8:40AM , from causes and on the date stated above.											
22a. SIGNATURE LT P. T. KIRCHNER,						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11 Sept. 1967			
22c. PHYSICIAN'S NAME (Type) LT P. T. KIRCHNER						22d. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/12/67		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City or Town) (County) (State) Washington, D. C.					
24. FUNERAL DIRECTOR Lee Funeral Home ADDRESS D. C.						25a. REC'D BY REGISTRAR SEP 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
4th and Massachusetts Ave., N.E. Washington											

(1999), 1999, 2000

6712390

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

10-1-1951

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12711

CERTIFICATE OF DEATH

12720

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Binghamton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>51 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>29 Mather Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Stephen</u> Last <u>Pasky</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 December 1898</u>		9. AGE (In years lost birthday) yrs. <u>68</u>	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Piskiewicz</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Kuc</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI & WWII</u>		16. SOCIAL SECURITY NO. <u>107-09-7843</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>289.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarction right cerebral hemisphere</u> DUE TO (c) <u>Systemic Amyloidosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>60 hours</u> <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute Renal Failure</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from <u>8 August</u> , 19 <u>67</u> , to <u>28 Sept.</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>28 Sept.</u> , 19 <u>67</u> , and that death occurred at <u>8:00 M.</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>H. Benfer Kaltreider, M.D.</u>				22b. DATE SIGNED <u>28 Sept. 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>H. Benfer Kaltreider, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct 2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	
24. FUNERAL DIRECTOR <u>R. J. Taku - 1930 Eastern Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100-443887-100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12712

12721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN IL <u>2 1/2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>411 Silver Spring Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Franklin Peacock</u> First Middle Last				4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-15</u>	9. AGE (In years lost birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosp. Walter Reed.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Robert Peacock</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Hammett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW2</u>		16. SOCIAL SECURITY NO. <u>579-16-5191</u>		17. INFORMANT <u>HELEN B. PEACOCK (Sister, 20 #2)</u> <u>& Patient's chart (HOSP.)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>9-27-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Print name, city, county for county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12713

CERTIFICATE OF DEATH

12722

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 47-3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Wash., D.C. b. COUNTY 47-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 859 Van Buren St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie Clanton Peebles First Middle Last 4. DATE OF DEATH Sept. 1, 1967 Month Day Year		5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/11/1896 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Jackson, N. C. 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Cain Clanton 14. MOTHER'S MAIDEN NAME Martha Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 229-22-9524 17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circumstances of death to be determined by medical examiner 159X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic obstructive pulmonary disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Aug 28, 1967 , to Sept 1, 1967 , that (I) (we) last saw the deceased alive on Aug 31, 1967 , and that death occurred at 7:30 A.M. , from causes and on the date stated above. 22a. SIGNATURE Henry D. Bell M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Dr. Emerson Williams 22d. ADDRESS 3809 14th St, N.W. 705 Kenyon St., N.W. Wash., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 9-1-67 23c. NAME OF CEMETERY OR CREMATORY Cofield Funeral Home 23d. LOCATION (City or Town) (County) (State) Weldon, North Carolina		24. FUNERAL DIRECTOR HALL BROS. 621 FIA AVE. N.W. WASH. D.C. 25a. REC'D BY REGISTRAR SEP 5 1967 25b. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12725

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Wash., D.C. b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 yrs. 3 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Althea Woodland Nursing Home 1000 Daleview Dr., Silver Spring		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 2301 Conn. Avenue N.W.	
3. NAME OF DECEASED (Type or print) Nell		4. DATE OF DEATH Month Sept. Day 18 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Smith		14. MOTHER'S MAIDEN NAME Ella Rust	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wentworth W. Peirce, Circle N.W.		Address 57 Observatory	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Arteriosclerotic Heart Disease. 4200 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR SEP 20 1967	
ADDRESS 5130 Wisc. Ave. NW. (DC)		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12715

12723

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>108 Croydon Ct. Apt 1-A</u>			
3. NAME OF DECEASED (Type or print) <u>Cecil Ray Pemberton</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-85</u>	9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retire Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Blg. Materials</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Ellis Pemberton</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hunt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>225-05-1635 A</u>		17. INFORMANT <u>Mrs. Juva J. Pemberton</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>3-4 days</u> <u>not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus (mild)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>off foot.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>9-1-</u> , 19 <u>67</u> , to <u>9-15</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>9-14</u> , 19 <u>67</u> , and that death occurred at <u>1262</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John R. Spencer</u>				22b. DATE SIGNED <u>9-15-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>				22d. ADDRESS <u>BURTONSVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Adelphi, Maryland</u>	
24. FUNERAL DIRECTOR <u>B. B. Thomas & Sons, 8434 Georgia Ave.</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

ELISA-90-7167XOFSI-715TJAFKAB

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12716

12724

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
o. COUNTY Montgomery		MARYLAND		o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				d. STREET ADDRESS 3201 Cummings Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First REBECCA		Middle PENSO		Last 9		Month 7 Day 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-92		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Turkey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NISSIM LEVY				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Jack Angel		Address 3201 Cum-mings Ln. Ch. Ch. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Pectoris DUE TO (c) Hypertensive Cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Mo 2 month about 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 46 , to Sept 11, 1967 , that (I) (we) last saw the deceased alive on 28 Aug 1967 , and that death occurred at 10 PM , from causes and on the date stated above.							
22a. SIGNATURE Clyde P. Reeves, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clyde P. Reeves, M.D.				22d. ADDRESS 1746 - K St., N.W., Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/10/67		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Cp. Heb. Cong. Cen.		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR B. DANZANSKY & SONS				25a. REC'D BY REGISTRAR SEP 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 3501 - 14th St. N.W.				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

STATEMENT OF EXPENSES

FOR THE YEAR 1961

BY THE ASSISTANT SECRETARY

FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

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FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

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FOR THE YEAR 1961

FOR THE YEAR 1961

FOR THE YEAR 1961

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12717

CERTIFICATE OF DEATH

12726

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>23 days 7 hrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>25503 Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>NMN</u> Last <u>Pollock</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 2, 1882</u> 85	
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NSW-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Jane Patterson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If so, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>265-02-8502</u>		17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Lobar -</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 wks</u>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>67</u> , to <u>9-15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-14</u> 19 <u>67</u> , and that death occurred at <u>3:30</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitlock</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9.15.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Whitlock, M.D.</u>				22d. ADDRESS <u>2217 Carroll Ave Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Sept. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100-100000

CERTIFICATE OF DEATH

100-100000

OFFICE OF THE ATTORNEY GENERAL

Washington, D. C.

John Doe

John Doe

John Doe

John Doe

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12718

CERTIFICATE OF DEATH

12727

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>				d. STREET ADDRESS <u>900 Caddington Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>(Wm)</u> Last <u>POLYCHRONAKIS</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Haneotakis</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>208-03-7327</u>		17. INFORMANT Address <u>SIL. SP. MD.</u> <u>MRS. PEARL N. CATORIS-900 CADDINGTON AVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple cerebrovascular acca</u> DUE TO (c) <u>4 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilat fractured hips. Old Tbc Inactive</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/18, 1967</u> to <u>9/19, 1967</u> that (I) (we) last saw the deceased alive on <u>9/19, 1967</u> , and that death occurred at <u>6 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ira N. Tublin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRA N. TUBLIN</u>				22d. ADDRESS <u>800 Pershing Drive Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. AIRY CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>NATRONA HEIGHTS, PENNA</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co - WASHINGTON, DC.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1813

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12719

CERTIFICATE OF DEATH

12728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

71
 Approved & Notified
 Dr. Bull

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Talcaoma Park md</u> c. LENGTH OF STAY in lb <u>17 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9202 Wendell St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>LEROY</u> Last <u>POWER</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7/7/03</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James H. Power</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Crowson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-0285</u>			
17. INFORMANT <u>Mary P. Power</u> Address <u>9202 Wendell St. Silver Spring, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS + HYPERTENSION</u> DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u>, 19<u>67</u>, to <u>9/1</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>9/1</u>, 19<u>67</u>, and that death occurred at <u>1:03</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>William S. Lyon M.D.</u>				22b. DATE SIGNED <u>9/1/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William S. Lyon</u>				22d. ADDRESS <u>1234 19th Street, N.W. Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City or Town) _____		(County) <u>Prince Georges Co. Md.</u>		(State) _____			
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

XXXXXXXXXXXX
Telephone

XXXXXXXXXXXX
Telephone Co.

XXXXXXXXXXXX
77/9/03

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12720

12729

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seaboard</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> 151 d. STREET ADDRESS <u>6707 Connecticut Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur N. Presmont</u> First Middle Last 4. DATE OF DEATH <u>Sept 23</u> 19 <u>67</u> Month Day Year			5. SEX <u>M</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <u>11-21-87</u> 9. AGE (In years last birthday) <u>79</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Phila. Pa</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Josias Presmont</u> 14. MOTHER'S MAIDEN NAME <u>Hannah Nathanson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>216-46-0959</u>		16. SOCIAL SECURITY NO. <u>216-46-0959</u> 17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u> <u>Vilma V. Presmont</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure.</u> 900.0 DUE TO (b) <u>Subdural Hematoma bilateral.</u> DUE TO (c) <u>Trauma from fall.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1/2 Months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Full down stairs at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>8/17</u> <u>8/6</u> 19 <u>67</u> Hour a.m. <u>2</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Cherry Chase Montgomery Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>9/24/67</u> Address (Street, city, town, or county) <u>Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>Forest Hills, Mass.</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12721

CERTIFICATE OF DEATH

12730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 47 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General				d. STREET ADDRESS 24816 Woodfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorraine Middle NMN Last Price				4. DATE OF DEATH Month Sept. Day 17 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-26-96	
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Claude Poindexter				14. MOTHER'S MAIDEN NAME Mary E. Carroll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-48-4527		17. INFORMANT Hospital Records, Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO 19 months (c) _____							INTERVAL BETWEEN ONSET AND DEATH 19 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-67 , 19____, to 9-17-67 , 19____, that (I) (we) last saw the deceased alive on 9-17-67 , 19____, and that death occurred at 4A M, from causes and on the date stated above.							
22a. SIGNATURE Chester L. Wagstaff				22b. DATE SIGNED Sept 17, 1967		22c. PHYSICIAN'S NAME (Type) Dr. Chester L. Wagstaff	
22d. ADDRESS Medical Center, Sandy Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR SEP 21 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

Pratt

Western Communications

June

2-11-52

X

Chick Luby Wood

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12722

12731

Item #9 Film #6392 9/13/67 pp

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bethesda		c. LENGTH OF STAY IN 1b MIDDLE		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 270				d. STREET ADDRESS 9 East Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vernon		First		Middle		Last		4. DATE OF DEATH September 6 1967	
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8.23.1913		9. AGE (In years last birthday) 54/82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SUGAR GROVE W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MELVIN PUFFENBERGER				14. MOTHER'S MAIDEN NAME EVA F WILFONG					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 11		17. INFORMANT MARY W PUFFENBERGER		Address HANCOCK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries multiple severe 8190 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Truck accident DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Seconds Seconds	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Deceased ran tractor trailer into bridge abutment at a high speed. Gasoline tank exploded and truck burned.							
20c. TIME OF INJURY Hour a.m. 5:30 p.m.		Month, Day, Year 9/6 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 270		20f. (City or town) (County) (State) None Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John S. Rogers, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 9/6/67	
EXAMINER'S NAME (Type) John S. Rogers, M.D.		Address (Street, city, town, or county) 1919 Seminary Rd. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9.9.67		23c. NAME OF CEMETERY OR CREMATORY GREAT CAPON		23d. LOCATION (City, town or county) (State) GREAT CAPON MORGAN W.VA.			
24. FUNERAL DIRECTOR Howard J. Shove		ADDRESS Hancock		25a. REC'D BY REGISTRAR OATE SEP 11 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jager			

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

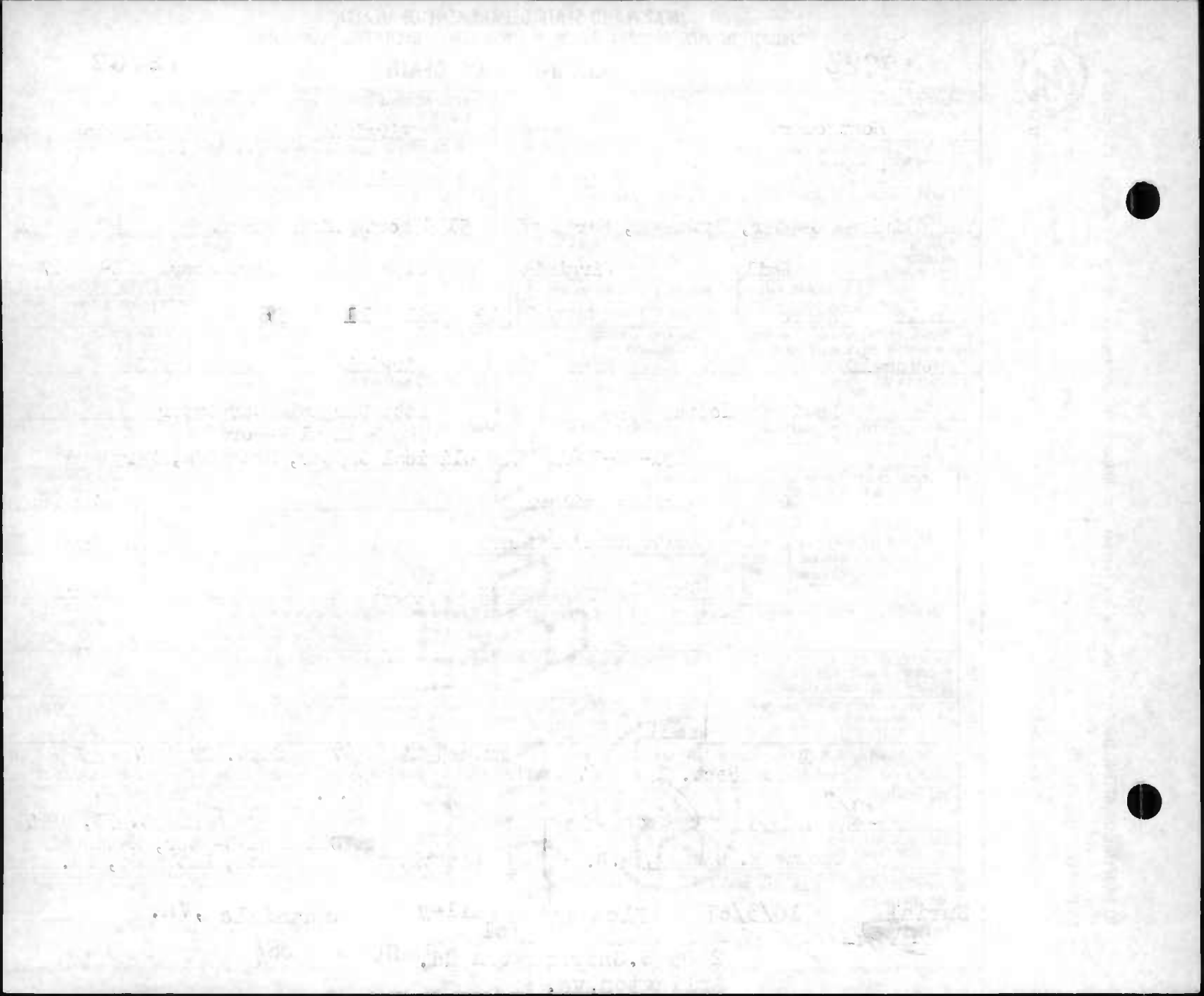
12723

CERTIFICATE OF DEATH

12732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>36 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83.3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>5135 North 22nd Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Virginia</u> Last <u>Randolph</u>				4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 April 1911</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Randolph</u>				14. MOTHER'S MAIDEN NAME <u>Etta Virginia Carpenter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-22-9864</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute Renal Failure</u> DUE TO (c) <u>Chronic Myelogenous Leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>29 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 24, 1967</u> , to <u>Sept. 29, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 29, 1967</u> , and that death occurred at <u>4:05 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas P. Clancy</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Sept. 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Clancy, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley</u>		23d. LOCATION (City or Town) (County) (State) <u>Annandale, Va.</u>	
24. FUNERAL HOME <u>Phillip Bill Church Funeral Home</u>				25a. REC'D BY REGISTRAR <u>OCT 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>2605 S. Shirlington Rd. Arlington, Va.</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12724

CERTIFICATE OF DEATH

12733

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>1108 Oakdale Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Elizabeth</u> Last <u>Ratterree</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-23-86</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>None Hsuf.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>La.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>							
13. FATHER'S NAME <u>William Jeffords</u>				14. MOTHER'S MAIDEN NAME <u>FLORANCE Clifton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-52 8282</u> <u>unknown</u>		17. INFORMANT <u>Med. records. Wash. San. Hosp.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> - cardiovascular failure DUE TO <u>cerebrovascular accident.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-17.67.</u> <u>24 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old age.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-4.</u> , 19 <u>67</u> , to <u>9-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-10</u> 19 <u>67</u> , and that death occurred at <u>7:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Veronica Troost</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST.</u>				22d. ADDRESS <u>10236 N. H. ave. Silver Spring Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>COLUMBIA SOUTH CAROLINA</u>	
24. FUNERAL DIRECTOR <u>W.W. Groggins & Inc.</u>				ADDRESS <u>RIVERDALE MD.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

1213

STATE OF TEXAS

1900

County of ...
State of ...
I, ...
do hereby certify that ...
is the true and correct copy of the ...
as the same appears from the records of this office.

Witness my hand and seal of office this ... day of ...
at ... Texas.

Notary Public for the State of Texas
My Comm. Expires ...
Subscribed and sworn to before me this ... day of ...
at ... Texas.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12725						12734					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>MONTGOMERY</u> MARYLAND						a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u> <u>47-3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON - D.C.</u>					
c. LENGTH OF STAY IN 1b <u>4 yrs + 3 mos.</u>						d. STREET ADDRESS <u>2715 18th St. N.E.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKE GROVE FOUNDATION</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LAURA Boggs REED</u>						4. DATE OF DEATH <u>9-9-1967</u>					
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>FEB. 22-1886</u> 9. AGE (In years last birthday) <u>81</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LANSBURG'S (SALES LADY)</u>						11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE Co - Md.</u>					
10b. KIND OF BUSINESS OR INDUSTRY <u>HEPT. STORE</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>WILLIAM BOGGS</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE PRISILLA ROTH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>571-24-8822</u>					
17. INFORMANT <u>WILLIAM S. O'DRYKE</u> Address <u>710 DEVONSHIRE RD TAKOMA PARK MD</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>											
(b) <u>PULMONARY EDEMA</u>											
(c) <u>ARTERIOSCLEROTIC C.V. DISEASE</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ORGANIC BRAIN SYNDROME, SENILITY</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>63</u> , to <u>9-9</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>7/28</u> , 19 <u>67</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>D. R. Lewis</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9-9-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>DONALD R. LEWIS</u> 22d. ADDRESS <u>700 CLOVERLY SILVER SPRING MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Sept 11, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>											
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll Ln N.W. D.C.</u> 25a. REC'D BY REGISTRAR <u>SEP 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>											

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

12726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12735

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON 833 d. STREET ADDRESS 2503 North 2ND Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred Lorraine Rice First Middle Last 4. DATE OF DEATH 9 - 10 1967 Month Day Year		5. SEX Female 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-29-16 9. AGE (In years lost birthday) 51 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) DOX. Maryland 12. CITIZEN OF WHAT COUNTRY? AMER.		13. FATHER'S NAME CHARLES SMITH 14. MOTHER'S MAIDEN NAME MARY ELLEN LIPPARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 578-40-0086		17. INFORMANT MR. GEORGE RICE - HUSBAND Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3220 Pending Acute alcoholism with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspiration of gastric contents DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Geap EXAMINER'S NAME (Type) BELDEN R. GEAP M.D.		22. DATE SIGNED 9/11/1967 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 14 Sept.	23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens	23d. LOCATION (City or town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR C. M. Gravel ADDRESS Murphy Funeral Home, Arlington, Virginia		25a. REC'D BY REGISTRAR SEP 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

[The page contains extremely faint, illegible markings and bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12727

CERTIFICATE OF DEATH

12736

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		d. STREET ADDRESS <u>305-N. Mulberry Street.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIE</u> Middle <u>F.</u> Last <u>Ridenour</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 1886</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>JOHN E. RIDENOUR</u>		14. MOTHER'S MAIDEN NAME <u>CELIA ROWLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> *****		16. SOCIAL SECURITY NO. <u>213-18-8043 T</u>	
17. INFORMANT <u>MRS. KATIE WIDDOWS, 305 N. MULBERRY STREET, HAGERSTOWN, MARYLAND.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probable Myocardial Infarction</u> DUE TO (c) <u>1 day</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>MRS. KATIE WIDDOWS</u> attended the deceased from <u>August 19 1967</u> to <u>present</u> 19 <u>67</u> , that (I) <u>she</u> last saw the deceased alive on <u>Sept 9</u> 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Fred A. Guy</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/12/67</u>
22c. PHYSICIAN'S NAME (Type) <u>FRED A. GUY, M.D.</u>		22d. ADDRESS <u>4743 BRADLEY LANE, CHEVY CHASE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN, WASH. CO. MD.</u>
24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

13131

RECEIVED OF DEATH

DEATH CERTIFICATE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12728

CERTIFICATE OF DEATH

12737

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN TB <u>3 1/2</u>		d. STREET ADDRESS <u>1220 Dale Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Howard Riegner</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-4-01</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H Riegner</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Schaal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>718-10-6066</u>	
17. INFORMANT <u>Mildred H. Riegner</u>		Address <u>1220 Dale Dr. Hospital Records Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> (c) <u>Artherosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 1/2 days</u> <u>Several days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anoxia due to Aspiration of Vomitus 4 1/2 days ago</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>October 19 57</u> to <u>9 Sept</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9 Sept</u> 19 <u>67</u> , and that death occurred at <u>12:30 P.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/9/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>1106 Spring Street Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Burial</u>	23b. DATE THEREOF <u>Sept. 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Norland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Chambersburg, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Glen Carter Warner & Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove rubber papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1887

CERTIFICATE OF DEATH

1887

Attest that on the 1st day of January 1900, at the City of New York, in the County of New York, I, the undersigned, a Justice of the Peace, have received from the family of the deceased, the following certificate of death, which I have read and find to be true and correct, and I have caused the same to be recorded in the office of the Registrar of the City of New York, in the County of New York, in the year of our Lord one thousand nine hundred and the year of our Independence the hundred and thirtieth.

Given under my hand and the seal of the City of New York, in the County of New York, this 1st day of January, 1900.

Justice of the Peace

Attest: My hand and the seal of the City of New York, in the County of New York, this 1st day of January, 1900.

Registrar of the City of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Saint Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YFS <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Robert Last RINK		4. DATE OF DEATH Month September Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 DECEMBER 1919
9. AGE (In years and birthdate) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY ADRC USN	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John RINK		14. MOTHER'S MAIDEN NAME Anna FULLERTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 10 JUN 41 - Sep 60 061-12-8017	
17. INFORMANT Madeline L. Rink		Address 73 Chinlee Drive Lexington Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Cirrhosis of Liver DUF TO (b) 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 11 August, 19 67 , to 2 Sep 19 67 , that (we) last saw the deceased alive on 2 Sep 19 67 , and that death occurred at 7:50AM , from causes and on the date stated above.			
22a. SIGNATURE H. S. BERG LT MC USN		22b. DATE SIGNED 3 Sep 1967	
22c. PHYSICIAN'S NAME (Type or print) H. S. BERG LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 Sep 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
25a. REC'D BY REGISTRAR DATE SEP 6 1967		25b. REGISTRAR'S SIGNATURE James J. Jones	

Saint Marys

Montgomery

Montgomery

Lexington

Lexington

Lexington

13 Chinese Drive

Naval Hospital, Bethesda, Md.

September 2

MINN

Robert

John

8 WASHINGTON

Wash. D.C.

NEW YORK

WASH DC

U. S. NAVY

JOHN RINK

JOHN RINK

13 Chinese Drive
Lexington, Va.

Washington D. C.

13-12-1941

13

Cirrhosis of liver

13

2 Sep

11 August

7:50A

13

2 Sep

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13 Sep 1941

Naval Hospital, Bethesda, Maryland

U. S. NAVY

Arlington, Virginia

Arlington Cemetery

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13-12-1941

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

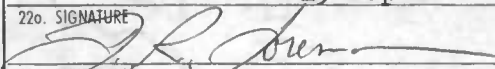
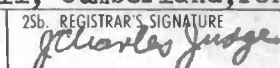
CERTIFICATE OF DEATH

12739

12730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY ST. MARYS		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 113 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS 47 E. Rennell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sylvia Rae RICHEL			4. DATE OF DEATH September 29 1967		
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Sep. 1940		9. AGE (In years lost birthday) 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Harrisburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sylvester U. Hammacher			14. MOTHER'S MAIDEN NAME Erma Kinter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 170 32 3316	17. INFORMANT James A. Richel 47 E. Rennell Ave. Lexington Pk., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus, Juvenile, refractory 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 13 , 19 67 , to Sept 29 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 29 Sept , 19 67 , and that death occurred at 4:45 PM , from causes and on the date stated above.					
22a. SIGNATURE 			22b. DATE SIGNED 30 Sept 1967		22c. PHYSICIAN'S NAME (Type) Lt D. R. FOREMAN, MC, USN
22d. ADDRESS Naval Hospital, NNMC, Bethesda, Md.			22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY Camp Hill	23d. LOCATION (City or Town) (County) (State) Camp Hill, Cumberland, Penn.		
24. FUNERAL DIRECTOR R. A. PUMPHREY, 7557 Wisconsin Ave. Bethesda, Maryland			25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE 

STATE OF DEATH

Marriage

Marriage

115 days

Marriage (Marriage)

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Marriage

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12731

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12740

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN <u>2 days/18 hrs.</u>		d. STREET ADDRESS <u>4009 4th St. S.E. Apt. 103</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>NMN</u> Last <u>ROACHER</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-37</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Pentagon (GOVT.)</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Lucille</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes Army-1956</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Extreme Internal Injuries with Hemorrhage.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased driver of car, struck guard rail & overturned vehicle.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:10 p.m. 9-9 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Wash., Dist. of Col.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>9/14/1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-17-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>CHURCH CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>RALEIGH, N. C.</u>	
24. FUNERAL DIRECTOR <u>JOHN T. RHINES FUNERAL HOME</u>		ADDRESS <u>3015 12TH ST. N. WASHINGTON, D.C.</u>	
25a. RECEIVED BY REGISTRAR <u>SEP 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

12732

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 17 Film G393 8/28/67 Jk

CERTIFICATE OF DEATH

12741

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>9 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>12711 Matthews Dr.</u> <u>1401 Brooks Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Robertson</u>				4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-80</u>		9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk, retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Robertson</u>				14. MOTHER'S MAIDEN NAME <u>Ann Wood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>44</u>		17. INFORMANT <u>James Robertson</u>		Address <u>Rockville, Md.</u> <u>614 Bloom Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> to <u>Sept</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/24</u> , 19 <u>67</u> , and that death occurred at <u>6:20</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>				22d. ADDRESS <u>8218 Wise Ave. Beth, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forty Fort Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Forty Fort Pa.</u>	
24. FUNERAL DIRECTOR <u>Warber E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Ga. Ave. Md.</u>		25. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12733

CERTIFICATE OF DEATH

12742

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>8107 TAHOMA Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>Bressler</u> Last <u>ROPKIN</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/01</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC Bressler</u>		14. MOTHER'S MAIDEN NAME <u>Tillie BRESSLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Susan Ropkin</u>		Address <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes - Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>67</u> , to <u>9/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Lewis Cahill</u>		22b. DATE SIGNED <u>9/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEWIS CAHILL</u>		22d. ADDRESS <u>5411 Cedar Lane Beth. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Cong. Cem. Washington, D.C.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>B. DANZANSKY & SONS - WASHINGTON DC</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

54736

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

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12734

CERTIFICATE OF DEATH

12743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>93 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>7108 Sycamore Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Alan</u> Middle <u>Arthur</u> Last <u>Rosenberger</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 May 1956</u>	
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James A. Rosenberger, Jr.</u>			
14. MOTHER'S MAIDEN NAME <u>Helen L. Derse</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Klebsiella Pneumonia</u> <u>2043</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Monilia Esophagitis</u> DUE TO (c) <u>Acute Myelogenous Leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 month</u> <u>26 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>21</u>	
20f. (City or town) (County) (State)							
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>June 20</u> <u>19 67</u> to <u>September</u> <u>19 67</u> , that <u>4</u> (we) last saw the deceased alive on <u>September 21</u> <u>19 67</u> and that death occurred at <u>7:25 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Creech</u>				22b. DATE SIGNED <u>Sept. 22, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Creech, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>Sept 25 1967</u>		<u>Fort Lincoln Cemetery</u>		<u>Colmar Manor Park, Md.</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll Rd NW LEC</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>				25c. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>			

THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12735

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12744

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY in 1b 149 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014				d. STREET ADDRESS 7508 Yorktown Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle (NMN) Last Roth				4. DATE OF DEATH Month September Day 14 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 August 1912	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 25 Days 20 Hours 10 Min.		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Hyman Weiner	
14. MOTHER'S MAIDEN NAME Pearl Schneider				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 092-01-3738				17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Thyrotoxicosis with Malignant Exophthalmus DUE TO (c) 8 months							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month 19 Day 19 Year 1967 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 April , 19 67 , to 14 Sept. , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on 14 Sept. , 19 67 , and that death occurred at 10:05M , from causes and on the date stated above.							
22a. SIGNATURE H. Benfer Kaltreider, M.D.				22b. DATE SIGNED Sept. 14, 1967		22c. PHYSICIAN'S NAME (Type) H. Benfer Kaltreider, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				22e. REC'D BY REGISTRAR SEP 20 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-17-67		23b. DATE THEREOF 9-17-67		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Norfolk, Va.	
24. FUNERAL DIRECTOR John 389 B. J. ...				25a. REGISTRAR'S SIGNATURE Charles Judge			

1210

CERTIFICATE OF DEATH

11/11/1917

11/11/1917

11/11/1917

The following is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, New York City, on the 11th day of November, 1917.

(1917)

(1917)

At New York, N.Y., this 11th day of November, 1917.

At New York, N.Y., this 11th day of November, 1917.

Witness my hand and the seal of the Registrar of Deaths, New York City, at New York, N.Y., this 11th day of November, 1917.

Witness my hand and the seal of the Registrar of Deaths, New York City, at New York, N.Y., this 11th day of November, 1917.

11/11/1917

11/11/1917

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11/11/1917

11/11/1917

At New York, N.Y., this 11th day of November, 1917.

At New York, N.Y., this 11th day of November, 1917.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18&21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH
10-5-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12745

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY MONT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				d. STREET ADDRESS 9514 Hale place			
3. NAME OF DECEASED (Type or print) First IRVING S Middle Rubin Last Rubin				4. DATE OF DEATH Month 9 Day 20 Year 1967			
5. SEX M	6. COLOR OR RACE AW	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1927	9. AGE (In years last birthday) yrs. 40	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist				10b. KIND OF BUSINESS OR INDUSTRY DRUGS		11. BIRTHPLACE (State or foreign country) JAVANNAH, GEORGIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jacob Rubin			
14. MOTHER'S MAIDEN NAME UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II			
16. SOCIAL SECURITY NO. UNKNOWN				17. INFORMANT NATHANIEL A. MILLER Address 1900 LYTONSVILLE RD SILVER SPRING, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Myocardial failure due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic interstitial myocarditis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED 9-20-1967				23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
24. FUNERAL DIRECTOR BELDEN R. REAP				25. REC'D BY REGISTRAR SEP 25 1967			
26. REGISTRAR'S SIGNATURE Charles Judge				27. ADDRESS 4217 9th St NW			
28. REMOVAL (Specify) BURIAL				29. DATE THEREOF 9-22-1967			
30. NAME OF CEMETERY OR CREMATORY NATL MEMORIAL PARK				31. LOCATION (City or Town) (County) (State) FALLS CHURCH VA.			

1000

RECEIVED

1000

1

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

VR A15 (4)
25M 1/67

3/6/51 -
 called per Dr. Ballou 9⁴⁵ AM - medical examiner
 P.P.R.

CERTIFICATE OF DEATH

12737

12746

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DISTRICT of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John B. Rubino</u>		4. DATE OF DEATH <u>9/3/1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luigi Rubino</u>		14. MOTHER'S MAIDEN NAME <u>Carmela Pantalona</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-24-8667</u>	
17. INFORMANT <u>Mrs. Mary C. Rubino (above address)</u>		Address <u>(Wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I (this hospital) attended the deceased from <u>Aug 31</u> , 19 <u>67</u> , to <u>Sept 3</u> , 19 <u>67</u> , that I (we) last saw the deceased alive on <u>Sept 2</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Sept 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ELG</u>		22d. ADDRESS <u>8641 Colomilla Rd Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) <u>Colmar Manor, Md.</u> (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>Nailey's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1912

CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15 1912

5. Place of death: Home

6. Cause of death: Heart disease

7. Signature of physician: J. H. Smith

8. Signature of registrar: W. B. Jones

9. Date of registration: Jan 16 1912

10. Place of registration: City of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top page, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12738

CERTIFICATE OF DEATH

12747

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Asbury Methodist Home</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Md.</u>				c. LENGTH OF STAY IN 1b <u>2 yrs. 8 Mo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Asbury Methodist Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest Clifford Saltzman</u>				4. DATE OF DEATH <u>September 24, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1977</u> <u>Jan. 1- 1977</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't. Office</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Marionville, Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Weshing Saltzman</u>				14. MOTHER'S MAIDEN NAME <u>Susan Amanda Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-14-5992A</u>		17. INFORMANT <u>Gladys S. Burgess</u> <u>4004 Beverly Road</u> <u>Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>Uncertain</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 22, 1967</u> , to <u>Sept 24, 1967</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Sept 24, 1967</u> , and that death occurred at <u>4:30 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>James W. Egan</u>				22b. DATE SIGNED <u>9/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. James W. Egan</u>	
22d. ADDRESS <u>5413 Cedar Lane 206C Bethesda Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR <u>Werner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1947

CERTIFICATE OF DEATH

Age of Deceased at Death

Place of Birth

Place of Death

Date of Death

Time of Death

Cause of Death

Place of Burial

Signature of Registrar

Signature of Deceased

Signature of Next of Kin

Signature of Medical Officer

Signature of Coroner

Signature of Police Officer

Signature of Constable

Signature of Driver

Signature of Witness

Signature of Registrar

Signature of Deceased

Signature of Next of Kin

Signature of Medical Officer

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12739

CERTIFICATE OF DEATH

12748

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47.3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>Butterworth Pl</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Sanders</u> Last <u>Sanders</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-2-97</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sandbrenka</u>		14. MOTHER'S MAIDEN NAME <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>188-16-19437</u>	
17. INFORMANT <u>Ralph Sanders</u>		Address <u>4416 Butterworth Pl. N.W.</u>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>584X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ascending Cholangitis</u> DUE TO (c) <u>Chronic Cholelithiasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1. ARTERIO SCLEROSIS (30 yrs)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/67</u> , 19 to <u>9/3/67</u> , 19, that (I) (we) last saw the deceased alive on <u>9/2/67</u> 19, and that death occurred at <u>6:50 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs MD.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/3/67</u>
22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD.</u>		22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Har Jehuda Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>North Darby Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		ADDRESS <u>3501-14th St., NW, Wash. D.C.</u>	25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			151		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 SCHINDLER DRIVE					d. STREET ADDRESS 1100 SCHINDLER DR.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) NICOLA First SCAMPOLI Middle SCAMPOLI Last					4. DATE OF DEATH Month 9 Day 24 Year 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 12, 1900		9. AGE (In years lost birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV.		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ANDREW SCAMPOLI					14. MOTHER'S MAIDEN NAME ROSAIRA M. STIVALETTI					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-10-1343		17. INFORMANT NATILIE KOLLEY			Address 10			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) metastases DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1967 to Sept 1967 , that (I) (we) lost saw the deceased alive on 9-23 1967 and that death occurred at 2 AM from the causes and on the date stated above.										
22a. SIGNATURE Bernard A. Fitzgerald					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD					22d. ADDRESS 217 UNIV. BLVD, SILVER SPRING MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-27-67		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET			23d. LOCATION (City, town, or county) (State) WASH. D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE HANLON FUNERAL HOME					ADDRESS WASH. D.C.		25a. REC'D BY REGISTRAR SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12741

12750

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5300 Westbard Ave				d. STREET ADDRESS Apt. 12 5300 Westbard Avenue			
3. NAME OF DECEASED (Type or print) Lillian R. Schafer				4. DATE OF DEATH Month Sept. Day 24 Year 1967			
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1877	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min.		11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home			
13. FATHER'S NAME Julius Eisenbeiss				14. MOTHER'S MAIDEN NAME Susanna Schaffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 332x			
17. INFORMANT Albert F. Esch				18. ADDRESS 9214 Cedar Way, Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis DUE TO (b) Generalized Atherosclerosis DUE TO (c) 5 yrs.				INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/13/67 , 19 to 9/24/67 , 19, that (I) (we) last saw the deceased alive on 8/13/67 , 19, and that death occurred at 1 A M, from causes and on the date stated above.							
22a. SIGNATURE Henry C. Scruggs MD				22b. DATE SIGNED 9/26/67			
22c. PHYSICIAN'S NAME (Type) Henry C. Scruggs MD				22d. ADDRESS 5413 Cedar Lane Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/67		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR W. Lawler Sons Inc.				25a. REC'D BY REGISTRAR DATE SEP 28 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

1273

RECORDS OF DEATH

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Alabama

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12743

12752

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Hb <u>200 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>15424 Tierra Lirio</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Wm.</u> Last <u>Schoenborn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/12</u>	
9. AGE (In years, last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u>		IF UNDER 24 HRS Hours <u>5</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired. physiologist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>physiologist</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Schoenborn</u>				14. MOTHER'S MAIDEN NAME <u>Marie James</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>412-48-5641</u>		17. INFORMANT <u>wife</u> Address <u>Clara Schoenborn/same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia and Multiple Brain Infarcts -</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of Right Hip -</u> DUE TO (c) <u>9 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic glomerulonephritis</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at home - causing fracture of Rt. H. H.</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. Nov 20 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Sept. 2, 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>				25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. ADDRESS <u>Warner E. Pumphrey Funeral Home Silver Spring, Md.</u>							

[Faint, illegible handwriting throughout the page]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12742

CERTIFICATE OF DEATH

12751

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY in lb <u>6 Months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> 15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>				d. STREET ADDRESS <u>10204 Carroll Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE L. SCOVELL</u>				4. DATE OF DEATH Month Day Year <u>Sept. 29, 19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1893</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Hicks</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Longton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter</u> <u>Joan E. Hekimian</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 DEHYDRATION SYNDROME</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC BRAIN SYNDROME</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 YEAR</u> <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-4-</u> , 19 <u>63</u> , to <u>9-29</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9-1-</u> , 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Samuel A. Hillman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <u>9-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>				22d. ADDRESS <u>8829 FLOWER AVE SILVER SPRING, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER NOTIFIED - will approve

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12744

12753

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9 Brooks Avenue		d. STREET ADDRESS 9 Brooks Ave	
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Selby		4. DATE OF DEATH Month Sept Day 6th Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 18th 1881
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY RR Supt.	11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY U S A		13. FATHER'S NAME Unknow	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Marion W. Selby	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 4214 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Valvular Heart Disease (c) Chronic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Gaithersburg		(County) Montgomery	
(State) Md.		21. I certify that (I) (this hospital) attended the deceased from 1965 to 9-6-67 , that (I) (we) last saw the deceased alive on 9-6-67 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.	
22a. SIGNATURE F.J. Broschert		22b. DATE SIGNED 9-7-67	
22c. PHYSICIAN'S NAME (Type) F.J. Broschert		22d. ADDRESS 11 Hutton St. Gaithersburg Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-9-67	
23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town or county) Gaithersburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Gaithersburg, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF ANALYSIS

1373

1904



[Faint, mostly illegible text from the main body of the certificate, including fields for sample description, analysis results, and signatures.]

SEE IT 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12745

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12754

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 2 days 12 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. & Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7504 Takoma Park d. STREET ADDRESS 7504 - Carroll Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle Hazel Last Sellers				4. DATE OF DEATH Month Sep Day 25 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/4/1905	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Semi-Mgr. Rooming House		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Montana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George S. Conger		14. MOTHER'S MAIDEN NAME Daisy Marr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-22-2211		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 1967 , that (I) (we) last saw the deceased alive on 1967 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Norman H. Rubenstein 22c. PHYSICIAN'S NAME (Type)						22b. DATE SIGNED SEP 29 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Home Inc. Nalley's Funeral				25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

IN SENATE,
January 12, 1904.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1904.

THE COMMISSIONERS OF THE LAND OFFICE HAVE THE HONOR TO ACKNOWLEDGE THE RECEIPT OF THE REPORT OF THE COMMISSIONERS OF THE LAND OFFICE, AND TO TRANSMIT THE SAME TO THE SENATE.

IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND SEAL OF OFFICE, AT ALBANY, N. Y., THIS 12TH DAY OF JANUARY, 1904.

JOHN C. BROWN, ATTORNEY GENERAL.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1904.

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IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND SEAL OF OFFICE, AT ALBANY, N. Y., THIS 12TH DAY OF JANUARY, 1904.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12746

CERTIFICATE OF DEATH

12755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove colored papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVERSPRING</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON, Md.</u>				d. STREET ADDRESS <u>4105 KNOWLES AVE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>C.</u> Last <u>SHERMAN</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/86</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James P. Raney</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Curtin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-10-7663D</u>		17. INFORMANT <u>Mary M. Sherman-Item # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5721</u> IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE - SHOCK</u> DUE TO (b) <u>ACUTE PERITONITIS DUE TO PERFORATION Cecum</u> DUE TO (c) <u>OBSTRUCTIVE SIGMOID DIVERTICULITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>19 HRS</u> <u>27 HRS</u> <u>48 HRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>9-4</u> , 19 <u>67</u> , to <u>9-5</u> , 19 <u>67</u> , that (I) (the) last saw the deceased alive on <u>9-5-1967</u> , and that death occurred at <u>7:20</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John P. Haberlin</u>				22b. DATE SIGNED <u>9-5-67</u>		22c. PHYSICIAN'S NAME (Type) <u>John P. Haberlin, M.D.</u>	
22d. ADDRESS <u>1015 Spring Street, Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> <u>Rockville, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Obstructive Sigmoid Diverticulitis 78442
Acute Peritonitis Due to Perforation (Case 27442)
Acute Renal Failure - Shock 19442

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12747		CERTIFICATE OF DEATH	
12756			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Cheverly</u>	
c. LENGTH OF STAY in lb <u>10 Months</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>1801 - 64th Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Catherine</u> <u>Virginia</u> <u>Shreve</u>		4. DATE OF DEATH <u>September 8</u> 1967	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Feb. 14, 1888</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Farmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alsop</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-03-1669</u>	
17. INFORMANT <u>Clarence B. Farmer</u>		8021 <u>Eastern Avenue</u> <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>11/14</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>66</u> to <u>Sept 8</u> , 1967, that (I) (we) last saw the deceased alive on <u>7/7</u> , 19 <u>67</u> , and that death occurred at <u>7:10</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>H F Kreuzburg</u>		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>		22d. ADDRESS <u>7852 16th Ave Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1000

STATE OF DEATH

1000

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Manner of death		8. Signature of physician		9. Signature of medical examiner		10. Signature of coroner	
11. Signature of registrar		12. Signature of funeral director		13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place	
16. Signature of family		17. Signature of friends		18. Signature of neighbors		19. Signature of community		20. Signature of church	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government		25. Signature of other	
26. Signature of other		27. Signature of other		28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other		34. Signature of other		35. Signature of other	
36. Signature of other		37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other		49. Signature of other		50. Signature of other	
51. Signature of other		52. Signature of other		53. Signature of other		54. Signature of other		55. Signature of other	
56. Signature of other		57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other		65. Signature of other	
66. Signature of other		67. Signature of other		68. Signature of other		69. Signature of other		70. Signature of other	
71. Signature of other		72. Signature of other		73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other		85. Signature of other	
86. Signature of other		87. Signature of other		88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other		94. Signature of other		95. Signature of other	
96. Signature of other		97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #c & d Film #G392 9/18/67 ph

12748

12757

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>45 Mins</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1118 Rockville Rd Bethesda 15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>5710 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>N.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 74 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Falls Church, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel R. Newlon</u>				14. MOTHER'S MAIDEN NAME <u>Magdalene Hogland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Son - Richard H. Smith</u>		Address <u>5710 Bradley Blvd Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>advanced generalized arteriosclerosis</u> DUE TO (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>5 Sept</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4 Sept</u> 19 <u>67</u> , and that death occurred at <u>9:37</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John M. Wyman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. WYMAN</u>				22d. ADDRESS <u>7801 Norfolk Ave. Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 335 LINCOLN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IRENE KELLY SMITH		4. DATE OF DEATH Month Day Year SEPTEMBER 6, 19 67	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-95
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME AARON BOARDLEY	
14. MOTHER'S MAIDEN NAME SARAH BROOKS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --	
16. SOCIAL SECURITY NO. --		17. INFORMANT MEDICAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic myocardial disease DUE TO (c) hypertensive arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, allice bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John S. Rogers, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John S. Rogers, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9-6-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/11/67	
23c. NAME OF CEMETERY OR CREMATORY LINCOLN PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) ROCKVILLE, MONTG. MD.	
24. FUNERAL DIRECTOR Robert L. Sworden		25a. REC'D BY REGISTRAR SEP 11 1967	
ADDRESS ROCKVILLE, MD. 20850		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Y. I. I.

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CHAMBERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12759	
12750										12759	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>29 years</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1803 Grace Church Road</i>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>1803 Grace Church Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>Josephine</i> Middle <i>J.</i> Last <i>Smith</i>					4. DATE OF DEATH Month <i>September</i> Day <i>23</i> Year <i>1967</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 12, 1890</i>		9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Don Home</i>		11. BIRTHPLACE (State or foreign country) <i>Mentor, Ohio</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Charles S. Johnson</i>					14. MOTHER'S MAIDEN NAME <i>Anna Cleveland</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>none</i>		INFORMANT <i>Silver Spring, Md.</i> <i>Howard R. Smith - 1803 Grace Church Road</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage, Acute, Intestinal</i> 2044 DUE TO <i>Leukemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i></i> DUE TO (c) <i></i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 day - 18 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <i>8:25</i> p.m. <i>Sept 23 1967</i>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>April 1, 1966</i> , to <i>Sept 23, 1967</i> , that I last saw the deceased alive on <i>Sept 23, 1967</i> , and that death occurred at <i>8:35 P.M.</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>George B. Patrick Jr.</i> M.D.					ADDRESS (Street, city or town, state) <i>9271 Colesville Rd Silver Spring, Md.</i>					DATE SIGNED <i>9-23-67</i>	
PHYSICIAN'S NAME (Type) <i>George B. Patrick, Jr., M.D.</i>					<i>Silver Spring, Md.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			22b. DATE THEREOF <i>Sept. 25, 1967</i>		22c. NAME OF CEMETERY OR CREMATORY <i>9th Lincoln</i>			22d. LOCATION (City, town, or county) (State) <i>Prince George Co. Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Glen Carter</i> ADDRESS <i>Silver Spring, Md.</i>					24a. RECEIVED BY REGISTRAR <i>SEP 27 1967</i>		24b. REGISTRAR'S SIGNATURE <i>James E. Pumphrey</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i> ADDRESS <i>8434 Ga. Ave.</i>											

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DIVISION OF DEATH RECORDS

NAME: [illegible]
SEX: [illegible]
AGE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
OFFICIAL: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12751

12760

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN TB 37 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 14601 Homecrest Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHLEEN AGNES SMITH		4. DATE OF DEATH Month SEPTEMBER Day 15 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/05 05
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 00 Days 06 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS COGAN		14. MOTHER'S MAIDEN NAME ELLA RALYEA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mr. Milford Smith		Address 14601 Homecrest Road Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 463X IMMEDIATE CAUSE (a) Pulmonary Infarct, Rt. L.L. DUE TO Thrombophlebitis, Lower extremities Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. weeks (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 10:15A		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 50 to Sept 15, 19 67 , that (I) (we) last saw the deceased alive on 9/15/67 19 67 , and that death occurred at 10:15A M, from causes and on the date stated above.			
22a. SIGNATURE Richard A. Yates M.D.		22b. DATE SIGNED 9/15/67	
22c. PHYSICIAN'S NAME (Type) RICHARD A. YATES, M.D.		22d. ADDRESS OLD BALTIMORE ROAD, OLNEY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cen.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR J. B. Thomas		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Md.		25c. REGISTRAR'S SIGNATURE J. Charles Jones	

12760

CERTIFICATE OF DEATH

WILLIAM HENRY HARRIS JR. Aged 38 years, died on September 18, 1964, at his home, 12760 12th Avenue, New York, New York.

WILLIAM HENRY HARRIS JR.

NEW YORK

12760 12th Avenue

NEW YORK

NEW YORK

12760 12th Avenue

NEW YORK

SEPTEMBER 18, 1964

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

WASHINGTON, D.C.

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12752

CERTIFICATE OF DEATH

12761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>6504 FLANDER DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>James Chester Stephenson</u>		4. DATE OF DEATH <u>9-22-1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>FLORIDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ERASMUS W. STEPHENSON</u>		14. MOTHER'S MAIDEN NAME <u>DAISY LINDSAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W. 2</u>		16. SOCIAL SECURITY NO. <u>578-16-7369</u>	
17. INFORMANT <u>VIRGINIA STEPHENSON</u> Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE & CIRCUMARY INSUF.</u> DUE TO (c) <u>CARDIAC ARRYTHMIAS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 HOURS</u> <u>10 MOS.</u> <u>6 MOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>SEPT 22 1967</u> , that (I) (we) last saw the deceased alive on <u>21 SEPT 1967</u> , and that death occurred at <u>5:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry R. Wolfe</u> M.D.		22b. DATE SIGNED <u>9/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE</u>		22d. ADDRESS <u>HYATTSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept. 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co Riverdale, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

10-11

OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

10-11

TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE CHIEF OF THE BUREAU OF THE ARMY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including dates, names, and specific details related to the subject matter. The text is organized into a structured format, likely following a standard military or government reporting protocol.]



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12753

CERTIFICATE OF DEATH

12762

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in 1b <u>16 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>				d. STREET ADDRESS <u>13216 Georgia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Stubbs</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 11, 1898</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME <u>Frank Dudley Stubbs</u>			
14. MOTHER'S MAIDEN NAME <u>Estelle Smith</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>			
16. SOCIAL SECURITY NO. <u>213-01-5860</u>		17. INFORMANT <u>Wife</u>		Address <u>Ethel L. Stubbs Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 HR.</u> <u>4 RS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis, Leukemia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Sept</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/19</u> 19 <u>67</u> , and that death occurred at <u>5:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>				22d. ADDRESS <u>4115 Colie Drive, Wheaton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-21-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with medical examiner

1978

CERTIFICATE OF DEATH

2/28/78

X

ALLS College, London, Maryland

FOR STATE
HEALTH DEPT.

12754

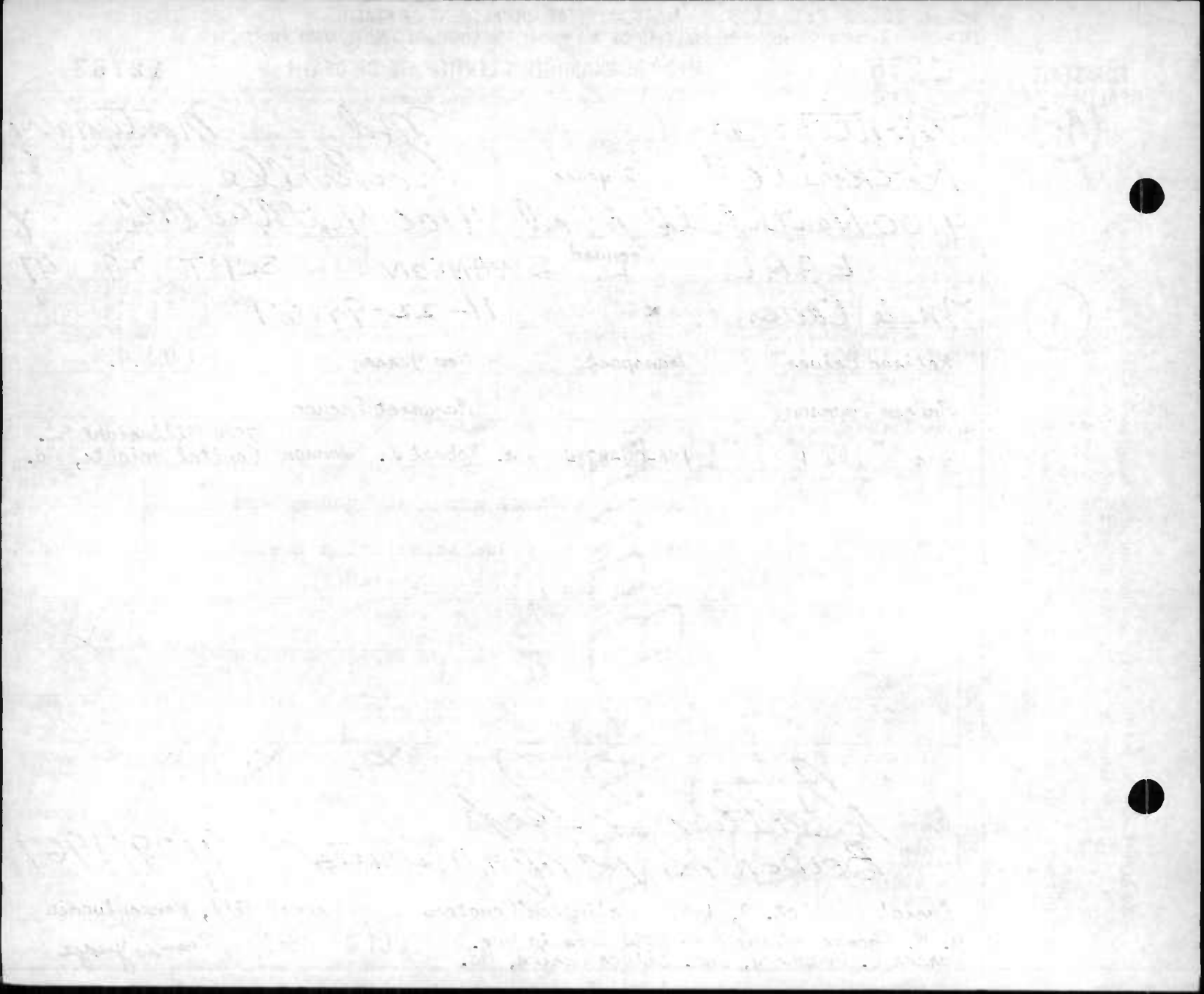
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4100 Heathfield Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>4100 Heathfield Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EARL</u> <u>Lequan</u> <u>SWANSON</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-99</u> <u>67</u>
9. AGE (In years) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transport</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Swanson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Spence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>186-09-8384</u>	
17. INFORMANT <u>Mr. Robert L. Swanson</u>		Address <u>7564 Millwright St. Capital Heights, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Acute pulmonary edema and congestive</u> DUE TO (b) <u>heart failure due to Hypertensive</u> DUE TO (c) <u>cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Whelan</u> Address (City or town or county)	
22. DATE SIGNED <u>9/29/1967</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Drexel Hill, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12755

12764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>				d. STREET ADDRESS <u>12400 Ellen Court</u>			
3. NAME OF DECEASED (Type or print) <u>Lydia</u> First <u>?</u> Middle <u>Suendiman</u> Last				4. DATE OF DEATH <u>Sept</u> Month <u>26</u> Day <u>1967</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-1883</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Dodge Center, Minn</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>ALBERT TRAPP</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE STARK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-46-1348</u>		17. INFORMANT <u>C. Spear RN</u> Address <u>Colonial Villa Nursing Home</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>WKS.</u> <u>YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>Sept 26, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 13, 1967</u> , and that death occurred at <u>9:42</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>				22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Sept. 27-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Dunbarburg Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Very respectfully,
Your obedient servant,
[Signature]

SEP 20 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>12 years</u>		d. STREET ADDRESS <u>8802 Lowell St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8802-Lowell St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>S</u> Middle <u>J</u> Last <u>Taylor</u>		4. DATE OF DEATH <u>Sept. 7</u> 19 <u>67</u> Month <u>Sept.</u> Day <u>7</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Curator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NRA</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>
13. FATHER'S NAME <u>Charles L. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Nina Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-07-9020</u>	17. INFORMANT <u>Blanche Taylor - Wife</u> Address <u>As above</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ARTERY DISEASE UNDET.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month <u>June</u> Day <u>9</u> Year <u>1967</u> Hour <u>8</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>58</u> to <u>SEPT 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/4</u> , 19 <u>67</u> , and that death occurred at <u>8:4</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence A. Rapee</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Sept. 7, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE A. RAPEE</u>		22d. ADDRESS <u>1732 Eye St. N.W. Wash, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> Address <u>5130 Wisc. Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

23 January 1918

Charles

M. W.

Curator

Charles L. Barber

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Nina Stewart

Washington DC

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May 12, 1918

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12766

12757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1055-B RIPLEY STREET</u>		d. STREET ADDRESS <u>8415 Woodcliff Court</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ROBERT</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refuse Co.</u>	9. AGE (In years last birthday) <u>61</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lindsay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Elizabeth H. Keyser</u>		Address <u>8415 Woodcliff Court Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>3221</u> IMMEDIATE CAUSE (a) <u>Fatty Metamorphosis of</u> DUE TO (b) <u>Liver due to Chronic</u> DUE TO (c) <u>Ethylism</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>9-25-1967</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12767

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 1661 Crescent Place N. W.	
3. NAME OF DECEASED (Type or print) First Harry Middle Raymond Last THURBER		4. DATE OF DEATH Month September Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1895
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy - Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Hoquiam, Washington		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank L. Thurber		14. MOTHER'S MAIDEN NAME Emma Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1918-1953		16. SOCIAL SECURITY NO. 579 56 9188	
17. INFORMANT Place, N.W.		Address Wash. D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus with local invasion 150X DUE TO of the trachea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from Sept. 8 , 19 67 , to Sept. 19 , 19 67 , that (A) (we) lost saw the deceased alive on Sept. 19 , 19 67 , and that death occurred at 225 PM , from causes and on the date stated above.			
22a. SIGNATURE J. T. Mullen		22b. DATE SIGNED Sept. 20, 1967	
22c. PHYSICIAN'S NAME (Type) J. T. MULLEN, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Jos. Gawler & Sons ADDRESS 5180 Wisconsin Ave., N. W. Washington, D. C.		25a. REC'D BY REGISTRAR SEP 27 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

12121

Ministry of Colonies

London

Local Government House

September 19

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Oct. 20, 1952

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Frank L. - Denver

Sept. 10, 1952

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Sept. 12, 1952

Sept. 12, 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12759

CERTIFICATE OF DEATH

12768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 24 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7003 Florida Street		d. STREET ADDRESS 7003 Florida Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIAN Middle L. Last TINKHAM		4. DATE OF DEATH Month September Day 22 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1888
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Horace W. Tinkham		14. MOTHER'S MAIDEN NAME Mary E. Slade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-5150	
17. INFORMANT Sister		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction severe 4201 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) Arteriosclerosis, generalised		INTERVAL BETWEEN ONSET AND DEATH 3 months 10 yrs + 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Diabetes Mellitus 2) Previous coronary occlusions		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 to Sept 22, 1967 , that I last saw the deceased alive on Sept 22, 1967 , and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 4740 Chevy Chase Dr DATE SIGNED 9-22-67	
PHYSICIAN'S NAME (Type) Stewart Clapp MD		Chevy Chase Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-67	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 29 1967	
24b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

12769

12750

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>40 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>13201 Foxden Drive</u>			
3. NAME OF DECEASED (Type or print) <u>L A RENE</u> First <u>RICHARDS</u> Middle <u>Torgesen</u> Last <u>Jorgesen</u>				4. DATE OF DEATH <u>September 20</u> 19 <u>67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23-1912</u>	9. AGE (in years lost birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative Officer Dist. Inst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(NBS)</u>		11. BIRTHPLACE (State or foreign country) <u>Malad City - Idaho</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Richards</u>				14. MOTHER'S MAIDEN NAME <u>Anna Justine Dudley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs John L. Jorgesen - Above</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>823.4</u> DUE TO <u>Injuries, multiple, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Automobile accident</u> DUE TO (c) <u>2 hrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of car & went off road and hit a utility pole & she was thrown</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>Sept 20 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>Highway</u>		20f. (City or town) <u>Rockville, Mont Md</u> (County) <u>3</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John S. Rogers M.D.</u>		ADDRESS (Home, city, town, or county) <u>1818 Seminary Rd. Silver Spring, Md.</u>		22. DATE SIGNED <u>Sept 20, 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) <u>Rockville, Md</u> (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

7-267452

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12761

12770

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA RURAL c. LENGTH OF STAY IN 1b 33 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US NAVAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD Maryland b. COUNTY MD Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MD Silver Spring 15-1 d. STREET ADDRESS 1203-Forest Glen Rd e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY/BOY (TWIN A) TOWNSEND First Middle Last 4. DATE OF DEATH SEPT. 16 1967 Month Day Year		5. SEX MALE 6. COLOR OR RACE CAUC 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 15 SEPT. 1967 9. AGE (In years lost birthday) 2 yrs. IF UNDER 1 YEAR Months Days Hours Min. 33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA 10b. KIND OF BUSINESS OR INDUSTRY NA 11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY MD. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RONNIE E. TOWNSEND 14. MOTHER'S MAIDEN NAME CYR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NA 16. SOCIAL SECURITY NO. NA 17. INFORMANT SILVER SPRING Address 1203 FOREST RONNIE E. TOWNSEND MD. GLEN RD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7735 IMMEDIATE CAUSE (a) PREMATURE HYALINE MEMBRANE DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 SEPT. 1967 , to 16 SEPT. 1967 , that (I) (we) last saw the deceased alive on 16 SEPT. 1967 , and that death occurred at 2:50 PM , from causes and on the date stated above.			
22a. SIGNATURE J. Tomasovic Capt AF M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 17 SEP 1967		22c. PHYSICIAN'S NAME (Type) CAPT J. TOMASOVIC, USAF 22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF Sept. 21, 1967 23c. NAME OF CEMETERY OR CREMATORY HIGHLAND BURIAL PARK 23d. LOCATION (City or Town) (County) (State) DANVILLE VA.		24. FUNERAL DIRECTOR W. E. PUMPHREY, INC ADDRESS 8434 Ga. Ave. Silver Spring, Md. 25a. REC'D BY REGISTRAR SEP 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

1373

CERTIFICATE OF DEATH

NAME (Last, First, Middle)		DATE OF BIRTH		PLACE OF BIRTH	
JOHN E. TONKIN		1925		HAWAII	
MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH	
U.S. NAVY		1968		HAWAII	
CAUSE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
HEART DISEASE		1968		HAWAII	
SIGNATURE OF REGISTRAR		DATE		PLACE	
[Signature]		1968		HAWAII	

NAME (Last, First, Middle)		DATE OF BIRTH		PLACE OF BIRTH	
JOHN E. TONKIN		1925		HAWAII	
MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH	
U.S. NAVY		1968		HAWAII	
CAUSE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
HEART DISEASE		1968		HAWAII	
SIGNATURE OF REGISTRAR		DATE		PLACE	
[Signature]		1968		HAWAII	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE XXX Maryland b. COUNTY XXX Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA RURAL			c. LENGTH OF STAY IN 1b 33 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXX Silver Spring 15/				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US NAVAL					d. STREET ADDRESS XXX 1203 Forest Glen Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY/GIRL (B TWIN) Middle TOWNSEND Last TOWNSEND					4. DATE OF DEATH Month SEPT. Day 16 Year 19 67				
5. SEX FEMALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 SEPT. 1967		9. AGE (In years last birthday) yrs. 33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA			10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY MD.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RONNIE E. TOWNSEND					14. MOTHER'S MAIDEN NAME CYR				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NA NA			16. SOCIAL SECURITY NO. NA		17. INFORMANT SILVER Address SPRING, MD. RONNIE E. TOWNSEND 1203 FOREST GLEN RD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURE HYALINE MEMBRANE DISEASE 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 SEPT. , 19 67 , to 16 SEPT. , 19 67 , that (I) (we) last saw the deceased alive on 16 SEPT. , 19 67 , and that death occurred at 5:25 PM , from causes and on the date stated above.									
22a. SIGNATURE J. Tomasovic					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 17 SEP 1967	
22c. PHYSICIAN'S NAME (Type) CAPT J. TOMASOVIC, USAF					22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY HIGHLAND BURIAL PARK			23d. LOCATION (City or Town) (County) (State) DANVILLE VA.		
24. FUNERAL DIRECTOR W. E. PUMPHREY, INC					25. REGISTRY BY REGISTRAR SEP 21 1967				
26. REGISTRAR'S SIGNATURE Charles Judge									

7-267462

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradford Rest Home, S.S.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> DC b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15810/Bradford Rd Washington</u> d. STREET ADDRESS <u>Silver Spring, Md.</u> <u>473</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>DOUGLAS ARCH</u> TURNER First Middle Last						4. DATE OF DEATH <u>9</u> <u>16</u> <u>1967</u> Month Day Year							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 27, 1893</u> <u>74</u> yrs.		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>579-18-5456</u>							
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Turner</u>						14. MOTHER'S MAIDEN NAME <u>Nancy DuLin</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>						16. SOCIAL SECURITY NO. <u>519-18-5456</u>							
17. INFORMANT Address													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Arteriosclerosis</u> (c) <u>Chronic Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 mos</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3-27-65</u> to <u>9-16-67</u> , that (I) (we) last saw the deceased alive on <u>9-15-67</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Oliver E. Jackson</u>						22b. DATE SIGNED <u>9-16-67</u>							
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>202 Martin Ln, Rockville Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>9/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Boyd's Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>George K. Brondan</u>						25a. REC'D BY REGISTRAR <u>SEP 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



7

1

(M)

12764

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12773

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Smithsburg</i>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>				d. STREET ADDRESS <i>211 Oakmont Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Linley S. Van Riper</i>		First Middle Last		4. DATE OF DEATH <i>Sept 1 1967</i>		Month Day Year	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-20-1905</i>	
9. AGE (In years last birthday) <i>62</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cartographer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Ray H. Van Riper</i>		14. MOTHER'S MAIDEN NAME <i>Becky Shaeffer</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>61161057</i>		17. INFORMANT <i>Wife - Ruth -</i>		Address		Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pos. cardiac myonade; massive</i> DUE TO <i>Ext ca of lung with pleural</i> (b) <i>metastasis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 13, 1967</i> , to <i>Sept 1, 1967</i> that (I) (we) last saw the deceased alive on <i>Aug 31, 1967</i> , and that death occurred at <i>7:15 A</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>V.C. de Guzman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9-1-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Vicente G. de Guzman</i>		22d. ADDRESS <i>1234 19th N.W. WASH DC.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 3, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Pleasant</i>		23d. LOCATION (City or Town) (County) (State) <i>Caneadea, New York</i>	
24. FUNERAL DIRECTOR <i>olin L. Molesworth, Damascus, Md.</i>				25a. REC'D BY REGISTRAR OATE <i>SEP 6 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1917

STATE OF NEW YORK

1917

BRANDON, NEW YORK

1917

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12765

12774

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2500 Q Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Van</u> Last <u>Voorst</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13 1897</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. ARMY</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geert Van Voorst</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes.</u>		16. SOCIAL SECURITY NO. <u>579-58-8038</u>	
17. INFORMANT <u>Phelia Van Voorst</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD, post myocardial infarction</u> DUE TO (c) <u>6 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 20, 1967</u> , to <u>Sept 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 20, 1967</u> , and that death occurred at <u>2:17 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George N. Polis</u>		22b. DATE SIGNED <u>9-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George N. Polis, M.D.</u>		22d. ADDRESS <u>1631 16th St. N.W., Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-29-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gauley, Sr. Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10-10-10

STATE OF DEATH

10-10-10



2

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12775

12765

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>YORK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u>		75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>2410 Markey Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stephen Nunley Vinson</u>				4. DATE OF DEATH Month Day Year <u>September 26, 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 September 1958</u>		9. AGE (In years last birthday) <u>9 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Curtis Vinson</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>The Medical Records The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease (Transposition of Great vessels)</u> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>9 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 24</u> , 19 <u>67</u> , to <u>Sept. 26</u> , 19 <u>67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 26</u> , 19 <u>67</u> , and that death occurred at <u>8:52 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Lynn M. Peterson</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>27 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lynn M. Peterson, MD.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Sept 27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>YORK YORK PA</u>	
24. FUNERAL DIRECTOR <u>BANNER STEVENSON MORT & FUN. Svc. YORK PA</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

1917

CERTIFICATE OF DEATH

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12767

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G396 1/18/68 yr

CERTIFICATE OF DEATH

12776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> <u>Austria</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>730 Hilda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>730 Hilda</u> <u>Klingenbach</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>100 S. Washington Street, Rock, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Ferenc</u> First <u>Völker</u> Middle Last		4. DATE OF DEATH <u>Sept. 21</u> 19 <u>67</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1911</u> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Managerial executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Executive</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>Jozsef Völker</u>		14. MOTHER'S MAIDEN NAME <u>Terkiz Kincis</u>	
15. WAS DECEASED IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>TL ditto M. Völker</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Carcinoma of the Lung</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> , 19 <u>67</u> , to <u>Sept 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-21</u> 19 <u>67</u> , and that death occurred at <u>6:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Corinne Cooper</u>		22b. DATE SIGNED <u>9-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		22d. ADDRESS <u>104 S. Washington Street, Rock, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 25 1967</u>	
Address <u>Rock Pike</u> <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1917

STATE OF NEW YORK

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Continued on page

State of New York

Division of Vital Records and Statistics

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12768

CERTIFICATE OF DEATH

12777

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sitter Spring Rockville, Md. 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>8641 1802 Henry Road</u>	
3. NAME OF DECEASED (Type or print) <u>Madeleine Rose</u> First Middle Lost		4. DATE OF DEATH <u>Sept. 7</u> 19 <u>67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1895</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey Co. Penn.</u>
13. FATHER'S NAME <u>Wm. Waidler</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Collier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-0590</u>	
		17. INFORMANT <u>Beverly Waidler-Item # 2</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>home</u> , 19 <u>66</u> to <u>Sept 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 6</u> , 19 <u>67</u> , and that death occurred at <u>4:59</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Blaine H. Eig</u>		22b. DATE SIGNED <u>Sept 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>8641 Colesville Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	23b. DATE THEREOF <u>9/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hale Eddy</u>	23d. LOCATION (City or Town) (County) (State) <u>Deposit, New York</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12777

STATE OF TEXAS

1

1900-1901

BRUCE H. ELL

184 (School)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

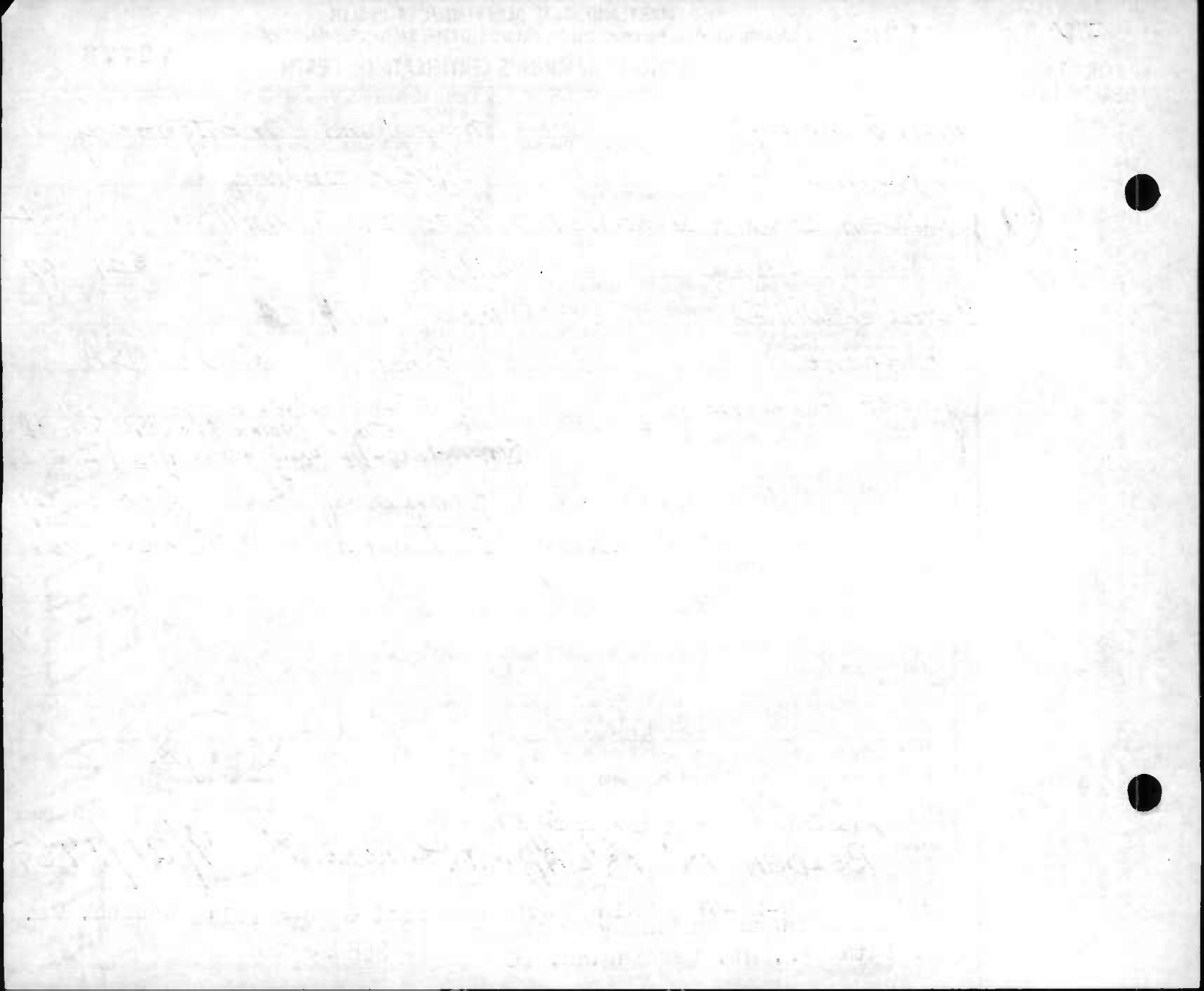
12769

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12778

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Lena</u> First Middle Last		4. DATE OF DEATH <u>Sept 21</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8-1894</u> 9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pinsk, Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Foreman</u> 14. MOTHER'S MAIDEN NAME <u>Yetta Soiberman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son-in-law, Dr. Harry Rosenzweig</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Heap</u> EXAMINER'S NAME (Type) <u>BELDEN R. HEAP M.D.</u>		22. DATE SIGNED <u>9/21/1967</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>	
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons</u> 3501 14th St., NW, Washington, DC		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



12770

12779

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 28days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING d. STREET ADDRESS 17701 DOMINION DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SIDNEY NMN WALTER First Middle Last 4. DATE OF DEATH 9 27 1967 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-22-96 9. AGE (In years lost birthday) 70 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D.C. 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS WALTER 14. MOTHER'S MAIDEN NAME SUE RAINES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 77 16. SOCIAL SECURITY NO. 4201 17. INFORMANT Mrs. Evelyn Leigh Address 1407 1/2 40th St. Baltimore, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiac muscle disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 minutes 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 , to Sept 27, 1967 , that (I) (we) last saw the deceased alive on Sept 27, 1967 , and that death occurred at 8:55 PM from causes and on the date stated above.			
22a. SIGNATURE A.D. Bonifant 22c. PHYSICIAN'S NAME (Type) A. DEMENT BONIFANT		22b. DATE SIGNED 9/27/67 22d. ADDRESS SANDY SPRING, MD.	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept 30-1967 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery 23d. LOCATION (City or Town) (County) (State) Adamsburg Rd. Pk. Md.		24. FUNERAL DIRECTOR Arthur Wallers 254 Carroll St NW 25a. REC'D BY REGISTRAR OCT 2 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12772

CAPITAN DE BARRA

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BANDY SPRING

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11-10-19

1701 EXHIBITION ST.

1701 EXHIBITION ST.

10-22-19

10-22-19

10-22-19

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10-22-19

WASHINGTON, D.C.

THE MARYLAND

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11-10-19

11-10-19

11-10-19

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 **12780**

CERTIFICATE OF DEATH

12771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY in 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hospital				d. STREET ADDRESS 8910 Flower Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claude Middle Marvin Last Ward				4. DATE OF DEATH Month Sept. Day 9 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-92	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Union		10b. KIND OF BUSINESS OR INDUSTRY Western Union		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Van Anderson WARD				14. MOTHER'S MAIDEN NAME Elizabeth Armstrong			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-09-852B		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarct DUE TO (c) ASHD						INTERVAL BETWEEN ONSET AND DEATH 10 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 28 , 19 67 , to Sept. 9 , 19 67 , that (I) (we) last saw the deceased alive on Sept 8 , 19 67 , and that death occurred at 7:10 A.M. from causes and on the date stated above.							
22a. SIGNATURE Marvin Schneider				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/9/67	
22c. PHYSICIAN'S NAME (Type) MARVIN SCHNEIDER, M.D.				22d. ADDRESS 911 Silver Spring Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR SEP 13 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12772

CERTIFICATE OF DEATH

12781

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp</u>				d. STREET ADDRESS <u>722 Easley Street</u>			
3. NAME OF DECEASED (Type or print) <u>John Scott Andrew Ward</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-81</u>	9. AGE (In years lost birthday) yrs. <u>86</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stokes County, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel David Ward</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Hutchinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>242-05-0723</u>		17. INFORMANT <u>Mary S. Ward</u> Address <u>722 Easley Street Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe progressive congestive heart failure</u> DUE TO (c) <u>Generalized Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>4 months</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular insufficiency</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>65</u> , to <u>September</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>September 19</u> , 19 <u>67</u> , and that death occurred at <u>11 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Harold W. Draper</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>September 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER M.D.</u>				22d. ADDRESS <u>911 Silver Spring Ave. Silver Spring.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>34 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared & Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12782

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10200 Hatherleigh Dr.		d. STREET ADDRESS 10200 Hatherleigh Dr.	
3. NAME OF DECEASED (Type or print) Catherine Earle Weber		4. DATE OF DEATH Month Sept. Day 11 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME --- Earle		14. MOTHER'S MAIDEN NAME ---Higgins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 264-80-1838	
17. INFORMANT Emil M. Weber - Husband same item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X HODGKINS DISEASE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from JUNE , 19 66 , to Sept 11 , 19 67 , that (I) (we) last saw the deceased alive on 9-9 , 19 67 , and that death occurred at 5:30 PM, from causes and on the date stated above.			
22a. SIGNATURE Richard B. Perry		22b. DATE SIGNED 9-11-67	
22c. PHYSICIAN'S NAME (Type) Richard B. Perry		22d. ADDRESS 2001 - EYE ST N.W. WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/15/67	23c. NAME OF CEMETERY OR CREMATORY Walnut Grove	23d. LOCATION (City or Town) (County) (State) Meriden - Connecticut
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

12774

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12783

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton, Md</u> d. STREET ADDRESS <u>Chesapeake Trailor Ct</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ronnie Calvin Wells</u> First Middle Last 4. DATE OF DEATH <u>9 3 1967</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-29-46</u> 9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Univ of Md</u> 11. BIRTHPLACE (State or foreign country) <u>Petersburg, Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Hunter Wells</u> 14. MOTHER'S MAIDEN NAME <u>Effie Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Dale Spence (step sister)</u> Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries Severe</u> DUE TO (b) <u>Trauma from Auto Accident.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car he was driving was struck at intersection</u>				20c. TIME OF INJURY Month, Day, Year <u>1255 a.m. 9/3/ 1967</u> 20d. INJURY OCCURRED <u>2</u> While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <u>Highway</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hyattsville Prince Georges Co Md</u> 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED <u>9/3/67</u>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G BALL</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12775

12784

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Conn. b. COUNTY Fairfield	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Wilton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland Nursing Home		d. STREET ADDRESS Cheese Spring Rd.	
3. NAME OF DECEASED (Type or print) Ethel Betts Weston		4. DATE OF DEATH Month 9 Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/1883
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 1 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Betts		14. MOTHER'S MAIDEN NAME Ellen Scofield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT 4427 Linnean Ave. N.W. WASH. D.C. Mrs. Neltze Vande Velde Dtr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Endarteriectomy Obliterations right leg		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to Sept , 19 67 , that (I) (we) last saw the deceased alive on Sept 15 , 19 67 , and that death occurred at 9:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Bernard A Fitzgerald		22b. DATE SIGNED 9-16-67	
22c. PHYSICIAN'S NAME (Type) BERNARD A FITZGERALD		22d. ADDRESS 217 UNIV. BLVD E, SILVER SP., MD	
23a. BURIAL, CREMATION, or other disposition of body Cremation		23b. DATE THEREOF 9/16/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Joseph Gawlre's Sons 5130 Wisc. Av. N.W.		25. REC'D BY REGISTRAR SEP 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12776

Item #4 Film #G393 10/18/67

CERTIFICATE OF DEATH

12785

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 3232 D Street, S.E.	
3. NAME OF DECEASED (Type or print) First George Middle Last Whaley		4. DATE OF DEATH Month Sept. Day 29 Year 1967	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dock Whaley		14. MOTHER'S MAIDEN NAME Martha Marble	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 245-16-0620	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Urinary Infection DUE TO (b) CVA & difficulty & resp. secretion DUE TO (c) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. / p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1 , 1967, to Sept 29 , 1967, that (I) (we) last saw the deceased alive on Sept 28 , 1967, and that death occurred at 5:45 M. from causes and on the date stated above.			
22a. SIGNATURE R. C. Bufalino		22b. DATE SIGNED Sept 29, 1967	
22c. PHYSICIAN'S NAME (Type) R. C. Bufalino		22d. ADDRESS 429 University Blvd. N.W. Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-3-67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY SHALBY-N.C.	23d. LOCATION (City or Town) (County) (State) SHALBY N.C.
24. FUNERAL DIRECTOR L. J. Langston - 611-K-S.N.W.		25. REC'D BY REGISTRAR DATE OCT 2 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12777

CERTIFICATE OF DEATH

12786

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN 1b 9-8-67		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 526 Powhatan Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rutledge Middle R. Last Wheeler				4. DATE OF DEATH Month Sept Day 19 Year 1967			
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/28/1904	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Robert Wheeler				14. MOTHER'S MAIDEN NAME Myrtle Grant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-20-7244		17. INFORMANT Address Mrs. MYRTLE W. BROWN 526 POWHATAN PL. N.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Debility & CVA 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary Infection Pyelonephritis DUE TO (c) Anemia						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acabone						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 19 , 19 67 , to Sept 19 , 19 67 , that (I) (we) last saw the deceased alive on Sept 17 , 19 67 , and that death occurred at 8 P. M. from causes and on the date stated above.							
22a. SIGNATURE R. C. Bufalino				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) R. C. Bufalino, M.D.	
22d. ADDRESS 1429 University Blvd. W. Silver Spring, Md.				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-23-67		23c. NAME OF CEMETERY OR CREMATORY UNION LINCOLN MEMORIAL		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR Rhine Funeral Home 3015-12th St. N.E. Wash. DC				25a. REC'D BY REGISTRAR SEP 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH										12787	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>1925 Calvert Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Agnes</u> First <u>Whitt</u> Middle <u>O</u> Last <u>Whitt</u>			4. DATE OF DEATH <u>Sept 21 1967</u>			5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>June 2, 1891</u> 9. AGE (In years last birthday) <u>76</u> 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>James Glenn</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>yes</u>		
17. INFORMANT <u>Agnes Whitt, 1801 Cypress Rd N.W. Wash D.C.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinsons disease</u> <u>350X</u> DUE TO (b) <u>arterio sclerosis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1936</u> , 19 <u>36</u> to <u>9/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>E.H. Markwood</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/21/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E.H. Markwood M.D.</u>						22d. ADDRESS <u>3208 - 17th N.W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 25, 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>		
24. FUNERAL DIRECTOR <u>John B. Thomas</u>			ADDRESS <u>8434 Georgia Ave.</u>			25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>			ADDRESS <u>Silver Spring, Md.</u>			25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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- Cleared by Medical Examiner 68

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15.1</u> d. STREET ADDRESS <u>11528 Lovejoy St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE D. Whittaker</u> First Middle Last 4. DATE OF DEATH <u>9</u> <u>29</u> <u>1967</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>18</u> - <u>30</u> - <u>94</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Paul Denno</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>017-07-1755</u>	
17. INFORMANT <u>James R. Whittaker</u> <u>11528 Lovejoy Street Silver Spring, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute posteroseptal myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Thrombosis right coronary artery</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 21, 1967</u> , to <u>Sept. 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept. 29, 1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>Sept. 29, 1967</u> 22d. ADDRESS <u>345 UNIV. BLVD W. SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 4 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>	

James W. Thompson

8-11-57

2002

24

2095-27-184

2492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
12780					12789					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>47.3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>			d. STREET ADDRESS <u>15 E. Street N. W.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oakhaven Convalescent Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Leovicy J. Williamson</u>			First Middle Last		4. DATE OF DEATH <u>Sept 26 1967</u>		Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 11, 1867</u>		9. AGE (In years last birthday) <u>99</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Samuel Turner Moore</u>					14. MOTHER'S MAIDEN NAME <u>Emma Jewelllyn Ferguson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>577-46-1712-J1</u>		17. INFORMANT <u>Mr Kathryn Kide</u> Address <u>15 E St NW, Wash DC</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>794 X</u> <u>Old congestive failure</u> DUE TO (b) <u>Old age, cachexia, arteriosclerosis</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> , 19 <u>67</u> to <u>9/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> , 19 <u>67</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Chas H Wolcott</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolcott</u>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>SH Thine Co</u>					ADDRESS <u>2901 14th N.W., D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
					DATE <u>OCT 2 1967</u>					

1887

Washington, D. C.

115 A Street N. E.

James I. Williamson

Dear Sir

F. W.

My dear

Book Order Constant
Washington, D. C.
1887

4

1

(M)

12781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12790

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
c. LENGTH OF STAY IN 1b <u>21 days</u>		d. STREET ADDRESS <u>10820 Georgia Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>George</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-90</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior Structural Engineer F.A.R. Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>		13. FATHER'S NAME <u>George R. Wilson</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Shutte</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>226-58-4872</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Prostatitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-24, 1967</u> , to <u>9-20, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-19-1967</u> , and that death occurred at <u>2:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Oliver E. Thompson</u> M.D.		22b. DATE SIGNED <u>9/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u>		22d. ADDRESS <u>901 Pershing Dr. S.S.-Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 25, 1967</u>	
23c. NAME OF CEMETERY OR CRMATORY <u>Shedden Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Clinton Mass.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20002</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1938

CERTIFICATE OF DEATH

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields for personal and medical information.]

1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #13 Film #G392 9/21/67 ph

12782

CERTIFICATE OF DEATH

12791

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 16 HRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 7211 EXETER RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JANE H. Wilson				4. DATE OF DEATH Month Day Year Sept. 7 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/24/81	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York	
13. FATHER'S NAME William Henwood				14. MOTHER'S MAIDEN NAME FRANCES Misdorn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT GRACE A. Wilson - DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis; Grand mal seizures						INTERVAL BETWEEN ONSET AND DEATH 30 min 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1967 , to Sept 7, 1967 , that (I) (we) lost the deceased alive on Sept 7, 1967 , and that death occurred at 10:30 A M, from causes and on the date stated above.							
22a. SIGNATURE Robert R. Montgomery				22b. DATE SIGNED Sept 7, 1967		22c. PHYSICIAN'S NAME (Type) ROBERT R. MONTGOMERY	
22d. ADDRESS 5411 CEDAR LANE BETHESDA		23a. REC'D BY REGISTRAR SEP 14 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-9-67		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR SEP 14 1967			

1878

CERTIFICATE OF

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12792

12783

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER, MARYLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>02-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Kathleen</u> Middle <u>M</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/1888</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME MAKER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NAPANEE, ONTARIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>JAMES BARTLETT</u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>(SON) ROCKVILLE, MARYLAND=ROAD</u> <u>MR. CHARLES E. WILSON THREE SISTERS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>422.1</u> DUE TO (b) <u>Pulmonary embolism and infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Circulatory stasis inactivity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized and cerebral arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>65</u> , to <u>9/14/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/12</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>George H. Mitchell</u>				22b. DATE SIGNED <u>7/14/67</u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. MITCHELL, M.D.</u>	
22d. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE, MD.</u>		22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/16/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>HYSONG'S FUNERAL HOME</u>		24b. ADDRESS <u>1500 O. ST., N.W. - WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10-10-52

STATE OF OHIO

JOHN W. BROWN

JOHN W. BROWN

JOHN W. BROWN

10

10/10/52

JOHN W. BROWN

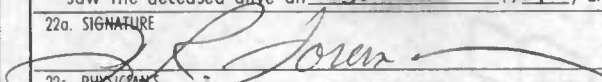
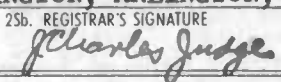
JOHN W. BROWN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12784		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12793	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN TB 25 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY SPRINGFIELD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. NAVAL HOSPITAL, BETHESDA, MD.		d. STREET ADDRESS 7920 E. ROCKGLEN COURT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STEVEN First BRUCE Middle WREN Last		4. DATE OF DEATH SEPT Month 30 Day 19 Year 67		5. SEX MALE	
6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 SEPT 1950	
9. AGE (In years last birthday) 17 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		11. BIRTHPLACE (County & State, or foreign country) OAKLAND, CALIFORNIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME WILLIAM E. WREN JR.		14. MOTHER'S MAIDEN NAME HARRIETT KARBEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT FATHER Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) LEUKEMIA, ACUTE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from 5 SEPT , 19 67 , to 30 SEPT , 19 67 , that (I) (we) last saw the deceased alive on 30 SEPT , 19 67 , and that death occurred at 4:55 PM , from causes and on the date stated above.					
22a. SIGNATURE 		22b. DATE SIGNED 30 SEPT 1967		22c. PHYSICIAN'S NAME (Type) LT D. R. FOREMAN, MC, USN	
22d. ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4 OCTOBER 67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY, ARLINGTON, ARLINGTON, VA.	
23d. LOCATION (City or town) _____ (County) _____ (State) _____		23e. REC'D BY REGISTRAR OCT 3 1967			
23f. REGISTRAR'S SIGNATURE 					

12181

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

OFFICE OF THE ATTORNEY GENERAL

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12794

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5902 MELVERN DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>R</u> Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1948</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N I H</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DENTAL TECH</u>	
11. BIRTHPLACE (State or foreign country) <u>EVERETT, MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William C. Wright</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE Raybould</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 1940-45</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Eleanor Wright - WIFE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination -</u> <u>977X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Laceration of Blood Vessels both Arms</u> DUE TO (c) <u>1/2 hr.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cut vessels both arms with razor -</u>	
20c. TIME OF INJURY Month, Day, Year <u>5⁰⁰ a.m. 9/27 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Bethesda Montgomery Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		22. DATE SIGNED <u>9/27/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>9-29-1967</u>	<u>Baltimore Nat'l. Cem.</u>	<u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DA <u>OCT 3 1967</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12786

12795

1. PLACE OF DEATH a. COUNTY <u>MONT.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>3 mths.</u>				d. STREET ADDRESS <u>1223 Woodside PKWY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HERBERT T. YEAGER</u> First Middle Last				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1902</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Realator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Freeburg, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Yeager</u>				14. MOTHER'S MAIDEN NAME <u>Amelia (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-075542</u>		17. INFORMANT <u>Mrs. Louise Yeager</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and chronic necrotizing pancreatitis</u> <u>58771</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with pancreatic pseudocyst</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Multiple myeloma</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> , 19 <u>63</u> , to <u>9/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> , 19 <u>67</u> , and that death occurred at <u>5:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Blaine H. Eig</u>				22b. DATE SIGNED <u>9/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Blaine H. Eig, M.D.</u>	
22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Sept. 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 21 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12730

CERTIFICATE OF DEATH

12730

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF VITAL RECORDS
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE OF DEATH: 12-15-1968

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: HOME

AGE: 78

SEX: F

RACE: W

EDUCATION: HS

RELIGION: CATHOLIC

CAUSE OF DEATH: HEART DISEASE

MANNER OF DEATH: NATURAL

DEATH CERTIFICATE NO. 12730

DATE OF BIRTH: 12-15-1900

PLACE OF BIRTH: NEW YORK

DATE OF DEATH: 12-15-1968

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: HOME

AGE: 78

SEX: F

RACE: W

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12787

12796

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Idaho</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>62 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Caldwell</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014 The Clinical Center, Bethesda, Maryland</u>					d. STREET ADDRESS <u>2114 Wisconsin Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virginia Janet Young</u>				4. DATE OF DEATH Month Day Year <u>September 26, 19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 October 1919</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wyoming</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Katy Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcal septicemia</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Metastatic ovarian carcinoma</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>16 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 26, 1967</u> , to <u>Sept. 26, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 26, 1967</u> , and that death occurred at <u>4:51 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Michael Emmer</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>27 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael Emmer, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-30-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Knowlton Heights Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Caldwell, Idaho</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>OCT 2 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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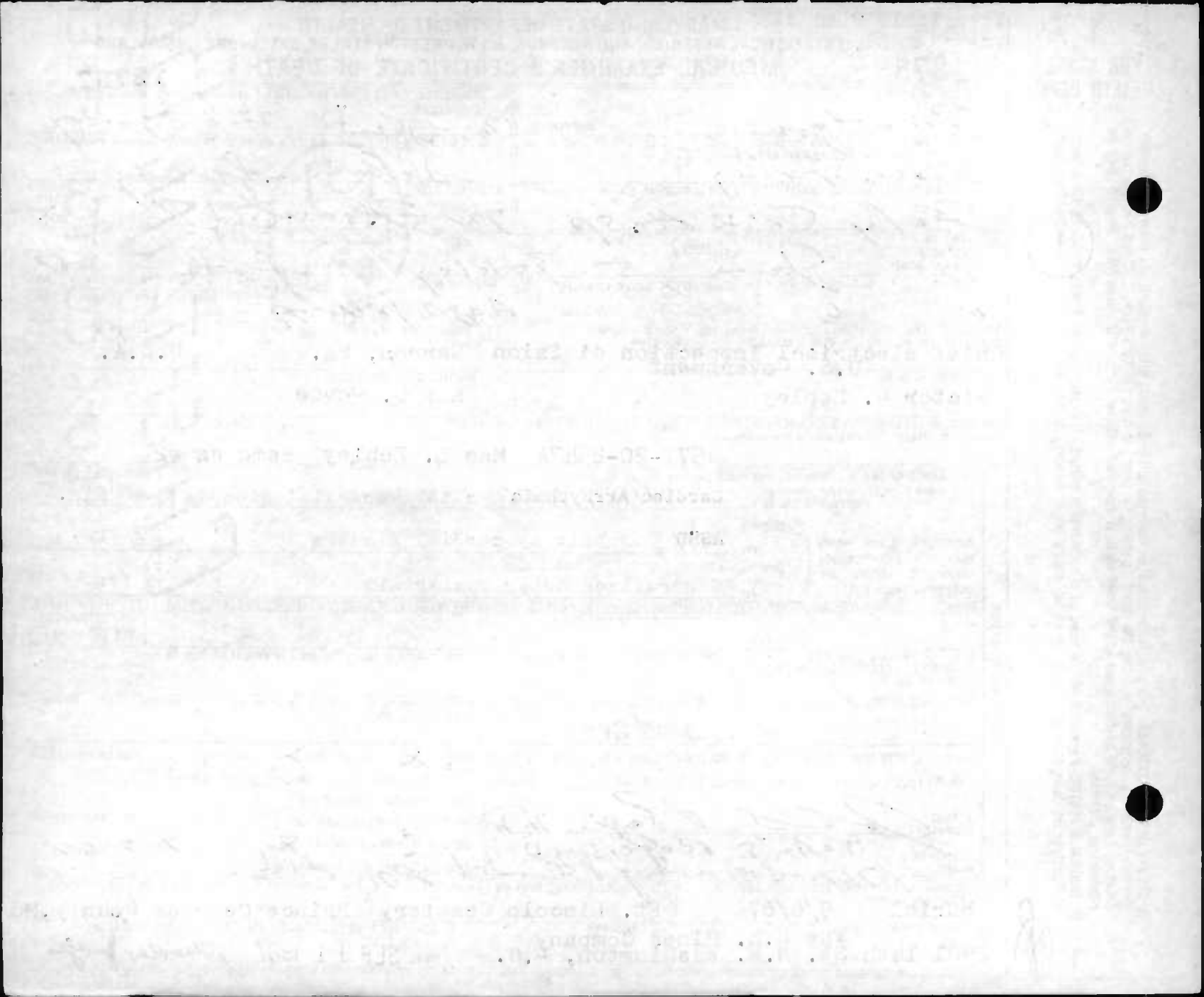
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>Items 18&19 Film 392</div> <div>9-14-67</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> </div>											
<div>12788</div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>MONTGOMERY</div> <div>MARYLAND</div>						<div>12797</div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>MARYLAND</div> <div>b. COUNTY</div> <div>Montgomery</div>					
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Flower Springs</div>				<div>c. LENGTH OF STAY IN 1b</div>		<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Flower Springs</div>				<div>d. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Holy Cross Hosp</div>						<div>d. STREET ADDRESS</div> <div>2315 Howard Rd</div>					
<div>3. NAME OF DECEASED (Type or print)</div> <div>James S Zebley</div>			<div>First (June)</div> <div>Month</div> <div>Last</div>			<div>4. DATE OF DEATH</div> <div>June 5 1967</div>			<div>5. SEX</div> <div>Male</div>		
<div>6. COLOR OR RACE</div> <div>W</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>April 2 1888</div>		<div>9. AGE (In years last birthday)</div> <div>79 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div>		<div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Chief electrician inspection division U.S. Government</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Chief electrician inspection division U.S. Government</div>						<div>11. BIRTHPLACE (State or foreign country)</div> <div>Warren, Pa.</div>			<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		
<div>13. FATHER'S NAME</div> <div>Victor C. Zebley</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>Ada C. Dovee</div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>(If yes give war or dates of service)</div>						<div>16. SOCIAL SECURITY NO.</div> <div>577-20-2547A</div>					
<div>17. INFORMANT</div> <div>Mae L. Zebley same as #2</div>						<div>Address</div>					
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Cardiac Arrhythmia Acute myocardial disease</div> <div>422.1 DUE TO (b) ASHD Chronic myocardial disease</div> <div>DUE TO (c) Generalized arteriosclerosis</div> <div>INTERVAL BETWEEN ONSET AND DEATH 40 min.</div> <div>2 yrs.</div> <div>Yrs.</div>											
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div> <div>None</div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>											
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>							
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town) (County) (State)</div>			
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>											
<div>ACTUAL SIGNATURE</div> <div>John S. Rogers M.D.</div> <div>EXAMINER'S NAME (Type)</div> <div>John S. Rogers M.D.</div>						<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>22. DATE SIGNED</div> <div>7-5-67</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>burial</div>				<div>23b. DATE THEREOF</div> <div>9/8/67</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Ft. Lincoln Cemetery</div>		<div>23d. LOCATION (City, town or county) (State)</div> <div>Prince Georges County, Md</div>			
<div>24. FUNERAL DIRECTOR</div> <div>The S.H. Hines Company</div> <div>2901 14th St. N.W. Washington, D.C.</div>						<div>25a. REC'D BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div> <div>OATE SEP 11 1967</div>					



CERTIFICATE OF DEATH

12798

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>17 hours</u>		d. STREET ADDRESS <u>9701 Old Spring Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irving</u> Middle <u>-</u> Last <u>Zitmore</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11 - 1907</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Managerment Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arthur Young & Co</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn - New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Max Zitmore</u>		14. MOTHER'S MAIDEN NAME <u>Ester Litov</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-32-1723</u>	
17. INFORMANT <u>Mrs. Melyce Perenstein</u>		Address <u>Arlington - VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO <u>Acute myocardial infarction</u> (b) <u>Coronary atherosclerosis</u> DUE TO <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>65</u> to <u>9/23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/23</u> 19 <u>67</u> , and that death occurred at <u>5:57 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Bernard J. Walsh</u>		22b. DATE SIGNED <u>9/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>		22d. ADDRESS <u>1500 Eye St. N.W. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON HEBREW CEM. WASHINGTON - D.C.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASHINGTON - DC</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>SEP 26 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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